

**Wisconsin**

UNIFORM APPLICATION  
2009

STATE IMPLEMENTATION REPORT  
COMMUNITY MENTAL HEALTH SERVICES  
BLOCK GRANT

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Center for Mental Health Services

Division of State and Community Systems Development

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

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## **Adult Plan**

### **Part D. Implementation Report**

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## ***Section I. Narrative Content of the Implementation Report***

### **1. Summary of Areas Previously Identified by State as Needing Improvement-Adults**

**Directions:** Report summary of areas which the state identified in the prior FY's approved Plan as needing improvement.

Information regarding areas in the adult public mental health system needing improvement was obtained through a Mental Health Council review committee meeting, a survey of county mental health administrators, and input from Bureau of Prevention Treatment and Recovery staff.

#### **1. Access to Services**

***There is a lack of access to dental services for mental health consumers.***

Access to dental services continues as an identified struggle for low-income consumers, as well as for those consumers and families who are Medical Assistance recipients in the state. Dental care services received increased focus during contract negotiations with HMOs to increase access, because only a few HMOs in Wisconsin cover dental services. The side effects of many psychotropic medications cause detrimental health outcomes for adults with serious and persistent severe mental illness, thus access to dental services is particularly important for mental health consumers.

***Coordination of services for consumers with multiple needs should be improved.***

Although coordination efforts are increasing, collaborative efforts between state agencies to serve consumers with multiple service needs is still a gap in the mental health service system. Consumers still must too frequently deal with uncoordinated services provided by different programs to address their multiple needs. As a result, duplication of services may occur or services are poorly planned due to the lack of coordination between programs. Opportunities for leadership in planning collaborative initiatives and facilitating collaboration among local providers still exist. The Comprehensive Community Services program will create an opportunity to begin collaborative efforts with the ability to fund integrated mental health and substance abuse treatment.

***Homeless adults who have a severe mental illness (SMI) are still underserved in Wisconsin.***

Despite the benefits the PATH initiative may bring, a great need to serve individuals who are homeless with a serious severe mental illness remains. While there are an estimated 7,641 individuals who are homeless with a serious severe mental illness in Wisconsin, the PATH initiative served approximately 2,000 individuals in FFY 2008. Additional homeless individuals may be served through counties and private agencies as mentioned above, but the priority given to serving homeless individuals is inconsistent among these other agencies. Homeless individuals can be difficult to serve due to their transient status and may sometimes receive a low priority for receiving mental health services. Many individuals who are homeless have both substance abuse disorders and serious severe mental illness (SMI). An estimated 50 percent of adults with SMI who are homeless have co-occurring mental health and substance abuse disorders. Additional needs for individuals who are homeless with a serious severe mental illness include screening,

assessment, and integrated treatment for co-occurring mental health and substance abuse disorders.

***There is a lack of ongoing and crisis services.***

There is a lack of ongoing services and crisis services across counties in the state. This also includes not only a lack of psychiatrists in rural areas, but urban areas. Certified crisis services would provide professional staff and support services both at the level of on-call and direct one-on-one response, 24 hours a day, seven days a week, to serve client and family needs. In addition, mobile crisis teams, with consumer/family participation, need to be able to provide effective diversion from hospitalization or incarceration when the crisis situation warrants it and suitable alternatives exist. Additionally, there is a lack in other types of mental health providers, such as social workers, clinicians, other direct service workers and clinicians that serve deaf and hard of hearing individuals.

***Many counties in Wisconsin are rural and programs to serve the rural mentally ill population need to be expanded.***

Addressing the mental health needs of the rural population deserves attention in Wisconsin because 58 of its 72 counties can be classified as rural. One of the strengths of the mental health system in Wisconsin is that the needs of the rural population are addressed in state statutes. Chapter 51 of the Wisconsin State Statutes mandates that mental health service needs be identified, budgeted for, and provided at the local level in all 72 counties. In addition, the Division of Mental Health and Substance Abuse Services (DMHSAS) continually makes a conscious effort to implement Community Support Programs (CSP) in every county. The current effort focuses on implementing CSPs in rural counties because they comprise most of the pool of remaining counties without a CSP. Additionally, tele-health is being implemented throughout the state and is increasing access for isolated, rural consumers to services. Finally, the implementation of CCS will be an opportunity for rural counties to provide integrated mental health and substance abuse treatment. CCS will be available to all counties and will be financially accessible when providers become certified and start billing Medicaid.

However, the overall needs of the adult rural population with severe mental illness are not adequately being met. Wisconsin's community mental health system has resource limitations. Most notably, mental health programs in rural areas often lack access to psychiatric and psychological services. Rural counties often have a difficult time recruiting psychiatrists and the cost of psychiatrists who are available is often higher than normal due to the extra travel time required to reach rural areas. In addition, a lack of personal and public transportation limits the consumer's ability to attend treatment. Long distances to consumer residences increase the difficulty for providers to deliver in-home services.

***There is a lack of mental health services in Wisconsin jails and prisons.***

There is a wide diversity in policy, and range of quality, in the treatment of mentally ill jail inmates in Wisconsin. There are over 60 county jails in Wisconsin. Each jail is administered independently by local authorities. Jail size varies considerably from a few inmates to hundreds. Locations are urban to rural. While some jails have links to the local human service providers, others have none. Many have hired private mental health providers that only answer to the jail administration. There are a number of jails, because of their location in rural areas, which do not have ready access to psychiatric services. As a result of all of the above, there is no statewide, accepted standard of care.

Items that should be addressed statewide include:

- Adopting evidence-based screening tools to identify individuals with severe mental illness and those at risk of suicide, and to ensure that jail staff have ongoing training.
- Having a private place and process for the intake screening and provision of medication.
- Involving Human Services in administering to severe mental illness or contracting with a trained mental health professional. If this is not possible, 24/7 access to consultation from a mental health professional is needed.
- Streamlining procedures to access medications to ensure no interruption in medication.
- Mobilizing crisis teams providing care to inmates in crisis in the jail.
- Providing additional resources to cover the cost of psychotropic medications.
- Having agreements with local hospitals to provide emergence services and hospitalization to inmates.

The Wisconsin Sheriff's and Deputy Sheriff's Association (WSDSA) reports that the provision of mental health care in the jails is an issue of tremendous economic importance to the counties and the sheriffs. There is concern about state mandates since sheriffs do not want to give up control of the jails to the state. However, they recognize the need to develop programs that may work across the counties. The Mental Health Criminal Justice Committee of the State Mental Health Council is addressing the provision of mental health care in Wisconsin Jails at this time with representation from the WSDSA and the Wisconsin County Human Services Association.

***There is a lack of transitional mental health services for individuals with mental illness from corrections back into the community.***

As offenders with severe mental illness re-enter the community and attempt to navigate the service systems, they often face considerable stress that undermines progress made toward recovery while in prison. Of all subgroups leaving prison, persons with severe mental illness have the least family and social supports available. Without family, friends or transitional services to turn to for assistance with day-to-day needs, many return to life on the streets and the familiar, if unsuccessful, coping patterns they adopted in the past. Those strategies often mean a return to prison life.

Re-entry into community life is difficult for the vast majority of offenders and recidivism rates remain high due to barriers to reintegration including: housing and employment challenges; social stigma attached to felons; poor family and personal support; lack of educational achievement; and poor personal and social skills. Mentally ill offenders face not only these challenges but also inadequate resources to meet their mental health needs at the local level. Mentally ill offenders must often wait in long lines with other community residents who are also accessing the scarce supply of physicians, therapists and affordable medication available to those who have little or no insurance. Appropriate discharge planning and follow-up support services are often not provided to connect offenders with the few resources that do exist within the community.

## **2. Provider Capacity**

### ***There is a lack of provider capacity in the state.***

It is reported that Wisconsin counties presently lack enough competent providers to serve consumers through the public mental health and substance abuse systems. With the expansion of Family Care (FC), this lack in provider capacity will increase. It is reported that approximately 55 percent of FC recipients have a severe mental illness diagnosis and all FC recipients are screened for mental health and substance abuse problems. As many of the FC recipients are not the same population that are currently served through the county mental health system, this means that there will be a significant increase in the demand for public mental health services in the future. Along with lack of provider capacity in the community, mental health competencies will need to be developed in Family Care staff.

Related to the lack of provider capacity is the institutionalization of mental health consumers who do not obtain the services they need in the community. Many consumers end up in hospitals, jails and homeless.

Wisconsin's community mental health system has resource limitations. Most notably, mental health programs in rural areas often lack access to psychiatric and psychological services. A number of counties in rural Wisconsin have a difficult time recruiting psychiatrists, and when they do they often must pay the psychiatrist from the time they leave their home or office, until they reach the county and begin to provide services. This means the county agency may use significant fiscal resources just for travel time in addition to the time the psychiatrist meets with consumers. To meet this challenge, Wisconsin is moving forward with allowing Medical Assistance (MA) reimbursement for mental health services provided through tele-health technology.

### ***Wisconsin has a county-based system.***

Wisconsin has a county-based system for delivery of mental health services. Counties are responsive to local needs and concerns and contribute significant funding for services. However, the system can lead to inconsistent implementation of programs county by county which causes great variation in access to services. Many counties have waiting lists for consumers in need of mental health services. While consumers are on the waiting list, few services from sources other than the county are available.

### ***There is a need for more meaningful participation of consumers in systems change activities.***

Wisconsin has embraced the President's New Freedom Commission on Mental Health's call for meaningful participation of consumers in systems change activities, but has not fully provided the tools to stakeholders to facilitate the process. Consumers need education, follow up technical assistance and support to participate in systems change activities such as policy and program input at the local level. Consumer input should be evident at the county, agency and program levels. Mental Health Block Grant funds have been utilized to provide stipends and reimbursements for consumers to advise the Department of Health Services (DHS) on issues affecting consumers. The Bureau of Prevention Treatment and Recovery's Consumer Affairs Coordinator also has provided some technical assistance and training to counties and the CCS initiative regarding consumer input on systems change. However, this policy needs to also be followed at the county level in order to be successful.

***There is a lack of coordination between the primary care and mental health systems.***

Individuals with severe mental illness often take multiple psychiatric medications. These medications, to varying degrees, all have side effects. Some of the more serious side effects include the extreme weight gain, diabetes, hypertension, metabolic syndrome, and cardiac difficulties associated with newer atypical antipsychotic medications. Individuals with severe mental illness also tend to smoke heavily. This leads to further risk of heart disease and cancer. It is critical that individuals with severe mental illness receive regular primary health care which is well-coordinated with their mental health care. It is clear that this is not adequately addressed at a state level or nationally as it has been reported by the National Association of State Mental Health Program Directors (NASMHPD) that people with severe mental illness die an average of 25 years earlier than a person without severe mental illness.

***There is a lack of resources to address individuals who have severe mental illness with significant behavioral challenges at the county level.***

There is the potential for counties to have their budgeted funds for treating adults with severe mental illness completely expended for a few high cost individuals. Particularly individuals who have severe mental illness with significant behavioral challenges can be very expensive. For example, one or two high-cost consumers at either of Wisconsin's state mental health institutes has the potential to utilize the entire budget, especially for smaller counties.

***Successful integrated planning and coordinated care is difficult because of the way mental health services are implemented across programs and counties.***

Many programs offering mental health services in the state have their own plan requirements and prescriptions for services. With the idea of person-centered planning and recovery-focused services, an overarching plan of care is developed that follows the person in their recovery process with changes made to measurable objectives as they move. Presently, the services available in various programs in the system are not consistent as individuals move through the continuum of care. Because of these varying service arrays in discrete programs along the continuum of care, it is difficult to obtain consistent funding, provide continuity of care or measure outcomes of recovery.

Comprehensive Community Services (CCS) and Coordinated Services Teams (CST) attempt to eliminate "silos" of services. In CCS, the advisory committee includes some members who are external providers and interested parties, in addition to consumers and families. As committee members, the providers and interested parties are able to provide feedback to the CCS program regarding policies, practices and procedures that are recovery-oriented and person-centered. This may also include practices that make it easier or harder for consumers to obtain services from multiple sources. The CCS program also develops Memoranda of Understanding (MOU) with its external partners in which the program requires a range of recovery-oriented and person-centered foci. For example, services must be psycho-social rehabilitative in nature, meaning that they must result in greater independence or minimizing of the effects of the illness. The services should reflect: positive results on quality indicators; participation on recovery teams; compliance with supervision and training to keep the staff skills current; and culturally competent services.

### **3. Funding**

***Trends in three major funding sources-Medicaid, Community Aids, County Tax Levy are creating an increasing strain on local tax levy.***

Critical community-based mental health services are funded with a combination of county matching funds and General Purpose Revenue (GPR). Counties provide more tax levy funding for mental health services than for any other disability group. Over 30 percent of the funding for mental health services is provided through the counties. The 09-11 Budget adds additional authority for the state/counties to launch the new MA-Benefit: Community Recovery Services through a 1915(i) waiver. This new program will allow MA-certified providers to bill Medicaid for in-home supportive services, supportive employment and peer/advocate supports. The state budget also adds \$1 million in GPR for community services in 2010 and an additional \$3 Million in 2011.

***There is a lack of mental health parity in the state.***

Parity legislation for mental health and substance abuse has yet to be enacted by the Wisconsin Legislature. In 2004, the state enacted Senate Bill 71, which prevents insurance companies from counting prescription drugs and lab testing against minimum coverage requirements for mental health services. This ensures that the full amount of minimum coverage will be available for mental health and substance abuse services. A bill to raise minimum coverage requirements for mental health services was introduced in both 2005 and 2007 in a Senate Sub-Committee but never made it to the floor and was not acted on in the Assembly. Parity has since been enacted at the federal level and it is unclear what effect this will have on Wisconsin mental health coverage requirements.

***There has been a reduction of funding for State staff positions to provide technical assistance to publicly funded mental health programs.***

With the increasing federal and state deficits and current economy, state funds for public mental health have declined. At the state level, staff positions are being frozen or eliminated by attrition due to the current recession. This affects the availability of state staff for technical assistance. State staff are also required to take 16 furlough days during the next two state fiscal years.

***Medicaid funding for mental health programs (CSP, CCS, Crisis) is inadequate.***

Wisconsin legislation requires that the non-federal share for Medicaid mental health services be paid from limited county tax dollars instead of state funds. As counties have a tax levy cap and competing programs other than mental health, funding for mental health programs is variable and contingent on local budget constraints. The county contribution to the cost of mental health services is a requirement unique to that type of service. Medicaid provides the non-federal share for other types of services.

***The structure of the premium system for the Medicaid Purchase Plan (MAPP) causes a disincentive for mental health consumers on SSI and SSDI to work enough to become independent.***

The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to buy health care coverage through the Wisconsin

Medicaid Program. Depending on an individual's income, a premium payment may be required for this health care coverage. Unfortunately, if the individual works enough hours to be charged a premium, the premium charged is as much or more than the consumer makes through working, thus causing a disincentive to work. The larger effect is to make it difficult for consumers to work toward full-time employment because of a loss in health care coverage. Many consumers have significant health care costs and entry level positions in the community often have a waiting period for health care coverage or no coverage at all. This creates a significant barrier to consumers who desire to transition back into the working mainstream to achieve their recovery goal of financial independence.

## **4. Data**

### ***Wisconsin's Mental Health Council (MHC) has concerns with Human Services Reporting System data.***

Last year, Council members were concerned about the quality and sources of data collected by the Department of Health Services (DHS). These concerns were particularly aimed at county services reporting which determined much of the plan implementation. Both the SAMHSA indicators and DHS data are critical for the State and Council to identify and support appropriate funding recommendations and decisions. The Council stated that their decisions about recommendations are more difficult due to inadequacies in both. They stated that they are pleased that the Department is committed to continue work to improve its data systems and quality. With the recent Data Infrastructure Grant, the Department is working toward incorporating the Medicaid HMO encounter-data system and improvements to the Human Services Reporting System (HSRS) data system.

DHS also recognizes that gaps still exist in data collection and reporting systems therefore preventing the State from having reliable data on the status of mental health consumers to assist in the future policy and programmatic decision-making processes. The most immediate needs for Wisconsin are to: continually enhance the State's reporting capabilities to comply with the URS Data Table requirements and use them for monitoring our mental health system's performance; increase overall reporting capabilities by continuing to refine the data warehouse; improve the quality of the data now reported through HSRS; and implement web-based technology for data collection and reporting.

## **5. Stigma**

### ***Stigma is an ongoing problem for Wisconsin's mental health consumers.***

The long term goal is the elimination of stigma and discrimination associated with severe mental illnesses in Wisconsin. Persons with severe mental illnesses and their families are impacted by the prevalence of stigmatizing beliefs and attitudes as well as systemic and environmental barriers and disincentives. Measurable outcomes will be achieved in the following areas for children, youth, adults and older adults, families, and veterans when:

- Mental health consumers have equal opportunity economically, socially, and culturally to positively contribute and work in their communities with access to education, training and employment;

- All Wisconsin residents have equal access to health insurance coverage with treatment services for mental, emotional and/or substance use illnesses that is on par for insurance coverage for other physical illnesses, unhampered by lesser insurance coverage policies and other coverage ceiling limits;
- The general public no longer believes perpetuated myths about persons and youth who have severe mental illnesses being more dangerous than others; and
- Cultural and self stigma with associated fear, embarrassment and the employment, economic and social burdens are reduced; and no longer force mental health consumers and their families to avoid treatment and unduly keep severe mental illness diagnoses and struggles private.

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

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## **Adult Plan**

### **Part D. Implementation Report**

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## ***Section I. Narrative Content of the Implementation Report***

### **2. Most Significant Events that Impacted the State Mental Health System in the Previous FY--Adult**

**Directions:** Report summary of the most significant events that impacted the mental health system of the State in the previous FY.

#### **Revision in the Standards for Outpatient Mental Health Clinics, ch. DHS 35**

New standards for outpatient mental health clinics, ch. DHS 35, were adopted by DHS and sent to the Legislative Reference Bureau (LRB) on January 29, 2009. The rule was published in May 2009. The effective date of the rule was June 1, 2009. A copy of the official published version of the rule may be found at <http://www.legis.state.wi.us/rsb/code/dhs/dhs035.pdf>

#### **Passage of Vendorship Bill**

As a part of the 2010-2011 State Budget, licensed social workers and marriage and family counselors will be able to directly bill Medicaid and private insurance for services, rather than only through outpatient mental health clinics.

#### **Expansion of Supplemental Security Income (SSI) Managed Care**

Since 2003, Wisconsin has been expanding SSI managed care across the state to adults receiving SSI living in the community, including persons with severe mental illness. Currently, the Medicaid SSI managed care program in Wisconsin covers 34 counties (11 were added in 2008) including over 11,000 individuals in Milwaukee and southeastern Wisconsin. Features of the MA SSI managed care program include:

- moderating initial risk with capitation and symmetrical risk sharing,
- excluding Medicaid clients who participate in Home and Community-Based waivers,
- carving out all county non-federal share mental health services (Crisis Intervention, CSP, Targeted Case Management, and CCS),
- other mental health services may be in the scope of managed care contracts with or without risk,
- ensuring that Managed Care Organizations (MCOs) contract with providers who can treat consumers with complex needs, such as persons with co-occurring substance abuse and severe mental illness as well as trauma survivors, and involve consumers in their treatment,
- including recovery principles and RESPECT in the contract and requiring/encouraging partnerships between agencies serving adults with disabilities and medical managed care experience, and
- implementing a quality monitoring system with the purpose of detecting and solving problems with HMO performance in a timely and ongoing manner.

Enrollment models for SSI managed care include the "all-in opt-out" and "voluntary" models. For programs with two or more HMOs available to choose from, which includes most of the SSI

managed care counties, the all-in opt-out option is utilized. For counties where there is one HMO available (currently about 15 counties), a voluntary enrollment is utilized.

As of March 1, 2008, the SSI managed care expanded into the following counties: Taylor, Clark, Marathon, Wood, Langlade, Menomonee, Oconto, Shawano, Waushara, Marquette, and Green Lake.

All-in opt-out counties prior to March 2008 include: Milwaukee, Waukesha, Racine, Kenosha, Washington, Ozaukee, Dodge, Jefferson, Manitowoc, Fond du Lac, Sheboygan, Waupaca, Winnebago, Brown, Rock Outagamie and Calumet.

Voluntary counties prior to March 2008 include: La Crosse, Trempealeau, Monroe, Buffalo, Jackson, and Vernon.

Stakeholders continue to be involved in SSI managed care. Advisory committees have been formed in each region with SSI managed care. The SSI Milwaukee/Southeast Managed Care Advisory Committee developed quality indicators to assess the efficacy of the different managed care organizations and reports have been developed with results for each indicator.

### **Contract Safeguards**

In addition to an in-depth evaluation of the provider network as a condition of certification, the contract contains the following provisions to ensure continuity of care:

- The HMO must authorize and cover services with the enrollee's current providers for the first 60 days of enrollment or until the first of the month following the completion of the assessment and care plan.
- The HMO must honor FFS prior authorizations at the level approved under FFS for 60 days or until the month following the HMO's completion of the assessment and care plan.

### **Contract Requirements for Care Management Include:**

- A comprehensive assessment and the development of a care plan for each enrollee.
- The HMO must submit a monthly detailed report of assessments to the Department.
- The HMO must conduct patient status and care plan review and updates as medically indicated, but at least annually as part of monitoring both clinical and non-clinical standards of care.

### **Issues Related to the Expansion of Family Care**

In February of 2006, Governor Doyle announced a goal to expand the Family Care program statewide over the next five years. Family Care provides long term care through regional managed care programs. Many of the individuals who would qualify for this program have co-occurring severe mental illness or substance abuse issues. Issues related to the expansion of Family Care Expansion include:

- 1. Unknown impact on the county mental health (MH) and substance abuse (SA) infrastructure.**

- A critical issue for counties is the need to remain financially solvent by retaining enough of an economy of scale (number of persons served) to support their infrastructure or fixed costs.
- The loss of community aids used to serve the target groups related to Family Care (developmentally disabled, physically disabled and older adults) significantly impacts a county's ability to flexibly shift funds from one target group to another based on the needs of all the target groups.

**2. Lack of provider capacity to serve increased demand for public mental health and substance abuse services due to increased identification of Family Care (FC) recipients with those issues.**

- It is reported that Wisconsin counties presently lack enough competent providers to serve consumers through the public mental health and substance abuse systems. With the expansion of FC this lack in provider capacity will increase.
- It is reported that approximately 55 percent of FC recipients have a severe mental illness diagnosis and all FC recipients are screened for mental health and substance abuse problems. As many of the FC recipients are not the same population served through the county mental health system, this means that a significant increase in the demand for public mental health services will occur.
- The number of recipients who received one or more mental health services in the public mental health system prior to FC enrollment was 4,472 or 49 percent of all FC and Wisconsin Pace Partnership recipients who enrolled for the first time on or after January 1, 2007 and were active on July 1, 2007. This is approximately half of the 55 percent of FC enrollees reported to have a diagnosis of severe mental illness.
- Along with lack of provider capacity in the community, mental health competencies will need to be developed in Family Care staff.

A fundamental concern is the underfunding of the public mental health system. This is compounded by how much of the funding is derived from county tax dollars and by the legislature imposing a cap or levy limits, and state aids remaining flat for years. Block grant funds from the FFY 2008 budget were allocated for a study of the impact of Family Care expansion as well as other developments including: BadgerCare Plus (expansion of low income health insurance to childless adults), Medicaid SSI Managed Care, Wisconsin Medicaid Cost Reporting (WIMCR) Initiative, ability to provide effective Community Support Programs (CSP) and Comprehensive Community Services (CCS), the establishment of a new Department of Children and Families, the increases in staff and infrastructure costs in counties taken out of treatment funds and other proposed changes on the horizon.

The Department expects the final report with results of the study to be presented at a Stakeholder Summit in early December 2009. Four possible models for financing the public mental health and substance abuse services system based on the data from the study will be presented at the Summit, which will be attended by county representatives, policy makers, providers, advocates,

consumers and other stakeholders. Representatives from other states will present examples of models that have worked well and some that have not worked so well. They will also present "lessons learned." The Summit will provide a panel of stakeholders to react to the presentations and to discuss any questions that arise during the summit. This will serve as the beginning of discussions regarding the redesign of the public mental health and substance abuse systems.

### **Status of Family Care Expansion**

Monroe, Green and Wood Counties began their transitions to Family Care in January 2009. Monroe County residents will be served by Western Wisconsin Cares, an eight-county public long-term care district. Wood county residents will be served by Community Care of Central Wisconsin, a three-county public long-term care district. Green County residents will be served by the Southwest Family Care Alliance, an eight-county public long-term care district. Approximately 54 percent of the Wisconsin population will be covered by a Managed Care Organization (MCO). Responses to a Request For Proposals (RFP) from organizations interested in providing Family Care to Milwaukee County residents with disabilities under age 60 or older adults have been evaluated.

### **BadgerCare Plus**

Wisconsin Medicaid began implementation of the BadgerCare Plus Program in February 2008. The program merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children, families, and childless adults. Coverage includes:

- All children (birth to age 19) with incomes above 185 percent of the federal poverty level (FPL).
- Pregnant women with incomes between 185 and 300 percent of the FPL.
- Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL.
- Caretaker relatives with incomes between 44 and 200 percent of the FPL.
- Parents with children in foster care with incomes up to 200 percent of the FPL.
- Youth (ages 18 through 20) aging out of foster care.
- Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent on depreciation calculations.
- Childless adults (ages 19 to 64) with income levels below 200 percent of the FPL

### **BadgerCare Plus Benchmark Coverage Plan**

The BadgerCare Plus Benchmark benefit plan is available to children and pregnant women with incomes above 200 percent of the FPL, certain self-employed parents, and other caretaker relatives. With two exceptions; the addition of preventive mental health and substance abuse counseling for pregnant women at risk of depression and the addition of OTC tobacco cessation products for pregnant women, covered services in the standard plan remains unchanged as a result of BadgerCare Plus. Covered services in the benchmark plan will be either the same as those in the standard plan (e.g., physician services) or lesser in amount, duration, or scope (e.g., dental services or therapy).

### Covered Services for Mental Health and Substance Abuse

- Outpatient mental health (same as the standard plan)
- Outpatient substance abuse (same as standard plan)
- Narcotic treatment services (same as the standard plan)
- Mental health day treatment for adults (same as the standard plan)
- Substance abuse day treatment for adults and children (same as the standard plan)
- Child/adolescent day treatment (same as the standard plan) - Note this is a Health Check “Other Services” benefit. Without providing this benefit, children will not have access to day treatment services.
- Inpatient Hospital (Services are covered under the hospital benefit but the limits and co-payments for mental health/substance abuse services are outlined below)

Covered service policies, such as diagnosis restrictions and physician prescription requirements, are the same as under the standard plan.

### Service Limitations

1. Services not covered: crisis intervention, community support program, comprehensive community services, outpatient services in the home and community for adults, substance abuse residential treatment, and in-home mental health and substance abuse services (Note: in-home mental health and substance abuse services is under Health Check “Other Services”. HMOs have the option to provide these services in the home under the outpatient mental health benefit).
2. For substance abuse, \$7,000 dollar amount limit per enrollment year and broken down by the following:
  - a. \$1,800 limit per enrollment year on outpatient substance abuse services
  - b. \$2,700 limit per enrollment year on outpatient substance abuse services and substance abuse day treatment
  - c. \$6,300 limit per enrollment year on inpatient hospital services

### **Expansion of BadgerCare Plus Coverage to Childless Adults**

The expansion of BadgerCare Plus extends coverage for basic health insurance to a population not served previously, including people with mental health and substance abuse services needs.

Childless adults that qualify for BadgerCare Plus have the following characteristics:

- Ages 19-64
- No dependent minor children
- Income at or below 200 percent of the FPL (\$20,800 for a single person, \$28,000 for two people)
- Not pregnant, disabled, or otherwise qualified for any other Medicaid, Medicare or SCHIP program
- No private health insurance coverage now or in the previous 12 months

Coverage for MH/SA services is limited to mental health therapy services provided by a psychiatrist only.

BadgerCare Plus provides access to basic health care services, including primary and preventive care and generic drugs in the form of a Core benefit plan. The BadgerCare Plus Core benefit plan will be less comprehensive than traditional Medicaid. Unfortunately, on October 9, 2009, the BadgerCare Plus Core Plan enrollment process was suspended. Medicaid is no longer enrolling new members in the Core Plan because the total number of applications received has been greater than the number of slots available. The Division of Health Care Access and Accountability has created a waitlist and people on the waitlist will be able to enroll in the Core Plan as space becomes available. While individuals are on the waitlist, they will be eligible for some health care services which are yet to be determined.

#### BadgerCare Plus Core Plus

BadgerCare Plus also offers employers and self-employed individuals the opportunity to purchase additional benefits in the form of Core Plus benefit plan. The BadgerCare Plus Core Plus benefit will enhance the Core benefit with additional limited services such as vision, dental, chiropractic, and outpatient mental health and substance abuse services.

The U.S. Department of Health and Human Services (DHHS) approved a demonstration project waiver of federal law and regulation that allowed DHS to implement the BadgerCare Plus Core Plan for Childless Adults in January of 2009. The initiative has started serving recipients formerly on general relief in Milwaukee County and a few other counties.

Covered MH/SA services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, and child/adolescent mental health day treatment and inpatient hospital stays for mental health and substance abuse.

Services not covered are crisis intervention, community support program (CSP), Comprehensive Community Services (CCS), outpatient services in the home and community for adults, and substance abuse residential treatment.

#### **Wisconsin Medicaid Cost Reporting (WIMCR) Initiative**

The Wisconsin Medicaid Cost Reporting Initiative is a financing system that allows the state to claim additional federal Medicaid funding for those services where the county provides additional county tax levy support when the Medicaid rates paid do not cover their full costs of providing Medicaid services such as crisis intervention, community support program or targeted case management services. Currently, the state collects this revenue and passes along a portion to county government.

#### **Psychosocial Rehabilitation Services--1915(i) State Plan Amendment**

Wisconsin plans to submit a 1915(i) state plan amendment to CMS in 2009. The application will be to cover psychosocial rehabilitation services. Under psychosocial rehabilitation Wisconsin will offer three services:

**Community Living Supportive services** – covering activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment.

**Supported employment** – Covers activities necessary to assist individuals to obtain and maintain competitive employment.

**Peer/Advocate Supports** – Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in emergency, outpatient, community or inpatient settings.

These services will be offered only in counties choosing to participate.

### **Nursing Home Relocation Waiver--Community Options in Recovery (COR)**

The Department submitted an application for a Home and Community-Based Waiver (HCBW) called Community Options in Recovery (COR) for persons who have a severe mental illness, to provide financial resources for relocation of some of these persons to an appropriate community setting. A new Medicaid 1915(c) Home and Community Based Waiver program was created with the goal of relocating residents of nursing homes who have co-occurring physical and mental health disabilities into the community. This waiver was approved in April of 2007 by the Centers for Medicare and Medicaid Services (CMS) and DMHSAS and has enrolled the first individual in this new relocation waiver in May of 2008. This waiver includes a package of service and case management supports appropriate for the target population, and long-term support services such as: supportive housing; adult family homes; community based residential facilities services; and respite care. The waiver also includes mental health community services such as counseling and therapeutic resources, observation-supervision, peer supports, daily living skills, job skills training; natural/family supports education and training, and transportation. Eligibility is based on nursing home eligibility, a diagnosis of severe mental illness, and the interest and ability of the individual to relocate into a community placement. Options will be offered to the individual to self-direct specific services.

COR is a relocation-only program for persons residing in nursing homes and living with serious mental illness and a co-occurring physical disability and who were determined via a Preadmission Screening and Resident Review (PASRR) Level II Screen to need specialized psychiatric rehabilitative services. Wisconsin's application was approved by the Centers for Medicaid & Medicare Services (CMS) for three years. Since the initial approval, DMHSAS has amended the start date with the amended expiration date of the waiver now being December 31, 2010. Unfortunately, COR's initial approval was delayed and thus by the time it was approved in May 2007 plans were well under way for Family Care Expansion. All persons who participate in a HCBS waiver program are eligible for Family Care and may enroll in Family Care or may return to the Medicaid fee-for-service system (i.e., all HCBS waiver programs cease to operate in Family Care counties). Therefore, once Family Care becomes available in a county, new enrollees cannot be accepted in COR waiver.

Placement plans for this population typically takes approximately six months. Thus, counties chose not to participate in a new waiver (COR) because their staff were focused on preparing for implementation and transition to Family Care. COR originally was expected to be mostly used by those counties who have county-operated nursing facilities that are providing specialized psychiatric rehabilitative services. There are currently only a handful of non-Family Care counties remaining and despite numerous contacts with them, none are interested in implementing the COR waiver program. Only Dane County is participating in the COR waiver. To date they have relocated five individuals from Badger Prairie Health Care Center to the community. Given this low level of participation, it is unlikely that COR will be renewed. Those individuals currently participating could then be transitioned to the Community Options Program (COP) Waiver.

## **Olmstead Grant--Later renamed the New Freedom Initiative Grant**

This grant was announced by the President in 2001 and aimed at promoting full access to community life through efforts to implement the Supreme Court's Olmstead decision, which was decided on June 22, 1999. States and the federal government began to develop responses to address issues related to the Olmstead decision. Funding and resources for these efforts initially were focused primarily on addressing the needs of older adults who are frail, physically disabled or developmentally disabled. Since 2001, the Center for Mental Health Services awarded grants of \$20,000 per year to all 50 states, the District of Columbia and two territories to help develop responses to Olmstead issues specifically for persons who have a mental illness. This grant was to help development of a coalition of persons and organizations to address Olmstead issues for persons who have a mental illness and to foster efforts towards one or more of the following goals related to Olmstead issues:

- Address the unique need of mental health financing
- Involve consumers and families fully in orienting the mental health system toward recovery
- Align relevant Federal programs to improve access and accountability for mental health services
- Protect and enhance the rights of people with mental illnesses
- Improve access to quality care that is culturally competent
- Improve and expand school mental health programs
- Improve and expand the workforce providing evidence-based mental health services and support

Wisconsin chose to use the Olmstead grant funds to develop a statewide coalition that helped to prioritize efforts to relocate persons who have a mental illness from nursing homes, primarily through the development of the COR waiver program. The planning process for the COR waiver program provided a foundation for the use of funds from related grant funds discussed below to move support the relocation of persons who have a mental illness from nursing homes.

## **Medicaid Preferred Drug List (PDL)**

To control costs and provide clinically sound drug therapy for recipients, the Wisconsin Division of Health Care Access and Accountability (HCAA) maintains a PDL and supplemental rebate program for Wisconsin Medicaid, BadgerCare and SeniorCare. Preferred Drug List recommendations are made to the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee based on the therapeutic significance of individual drugs and the cost-effectiveness and supplemental rebates with drug manufacturers. Drugs included on the PDL are recommended to the PA Advisory Committee based on research from peer-reviewed medical literature, drug studies and trials, and clinical information prepared by clinical pharmacists. Secretary Karen Timberlake of DHS formed a Mental Health Drug Advisors Group made up of mental health consumers, family members, psychiatrists and advocates to advise her on the review of mental health drugs.

## **Shortage of Psychiatric Providers for Adults**

There is a shortage of psychiatrists and psychologists for adults in Wisconsin in the public mental health system in urban and rural areas. Many factors contribute to the shortage. There is even a

greater paucity of gero-psychiatrists and a lack of psychologists/psychiatrists who are deaf or hard of hearing and/or are conversant in sign-language at the professional level.

National studies show residency programs are not graduating enough psychiatrists to fill the need, even though in the next five to 10 years the demand will increase by 100 percent for children requiring mental health services and 19 percent to 20 percent for adults. The need is growing. The National Alliance on Mental Illness (NAMI) estimates one in four families nationwide has someone with severe mental illness.

Dr. Ronald Diamond, M.D., a University of Wisconsin-Madison psychiatrist states that although Wisconsin is in a little better shape than other parts of the country with the exception of rural areas, there is an absolute shortage of psychiatrists and psychologists in Wisconsin. Dr. Diamond, the consultant to the Bureau of Prevention Treatment and Recovery and medical director of Dane County's Mental Health Center, states several factors contribute to the shortage:

- Parity: Wisconsin does not require insurers to cover mental health treatment on "a par" with other medical illnesses like diabetes.
- Numbers: In 2008, UW-Madison and UW-Milwaukee each graduated eight psychiatrists. State hospitals, which once turned out a good supply of psychiatrists, no longer offer training programs. Also, those who graduate have their pick of jobs nationwide and most prefer to live in high population centers.
- Pay: Financially, psychiatry cannot compete with more lucrative specialties such as cardiology. A cardiovascular surgeon makes an average of \$558,719 compared to an average of \$169,000 for a psychiatrist, according to an Allied Physicians (2003-06) national salary survey.

While very good, pay generally is closer to that of a primary care doctor or pediatrician. Also factored in are quality of life and such job issues as call coverage for nights, weekends and vacations.

- Appeal: Relatively few medical students go into psychiatry because psychiatrists face the same societal stigma as consumers.
- Training: Psychiatry requires four years of residency following medical school, plus one or two years of further study depending on the psychiatric specialty.
- Funding: Federal and state funding for training has become scarcer over the years, and along with it, a faculty support system to mentor those considering the field. Higher salaried specialties are much more able to fund their own training through patient revenue.

### **Revision of Ch. HFS 63 Administrative Rules (Community Support Program)**

Work will begin in 2010 on revision of the Community Support Program Administrative Rules for Wisconsin. Ch. HFS 63 is outdated and has not been reviewed or rewritten since May 1, 1989. The new rules will incorporate new State and Federal requirements and developments, incorporate significant changes in practice, treatment and language coming out of research and the consumer movement.

### **Forward Health InterChange (new Medicaid Management Information System) Implementation**

The new Medicaid Management Information System (MMIS) called Forward Health interchange has been operational since full implementation on November 10, 2008. Financial and claims processing payment cycles have completed each week as scheduled and total payments continue to increase each week. Communication and outreach to all stakeholder groups continue weekly to address concerns, and status of the system and operations.

### **Joint Statement on "The Integration of Physical Health, Mental Health, Substance Use, and Addiction"**

On January 12, 2009, Secretary Timberlake issued a letter supporting the Department's joint statement on "The Integration of Physical Health, Mental Health, Substance Use, and Addiction." Secretary Timberlake stated that within DHS, a joint statement and actions steps were created to "bridge illness prevention and management, health promotion, public education and awareness efforts." She stated that the goal is to improve the lives of Wisconsin's citizens, "leading people of all ages, from all families and communities to optimal physical, mental, social, emotional, and spiritual health." The Joint Statement, Endorsement Form, and Action Step Objectives are located on the Department website at <http://dhs.wisconsin.gov/mentalhealth/jointstatement/index.htm>

### **County Responsibility for Non Federal Share Inpatient Costs of State Mental Health Institutes**

Beginning January 2010, counties will be responsible for paying the non federal share of the costs for inpatient stays for children and older adults at the state mental health institutes.

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

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## **Adult Plan**

### **Part D. Implementation Report**

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**Section I. Narrative Content of the Implementation Report**

**3. Purpose State FY BG Expended-Recipients - Activities Description--Adults**

**Directions:** A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

**Expenditure Report**

**Overall FFY 2009 Mental Health Block Grant Expenditures/Allocations**

**Table 1  
FFY 2009 MHBG Expenditures by Program Area**

<b>Title</b>	<b>Time Period</b>	<b>Expenditures</b>
<b>Community Aids for all counties</b>	CY 08	\$2,475,922
<b>Children's MH Programs</b>		
ISP	CY 08	\$1,306,700
CST (7 Counties)	FFY 09	\$183,312
CST TA (Waupaca County)	FFY 09	\$119,351
CST (2 Tribes)	FFY 09	\$51,764
<b>Subtotal</b>		<b>\$1,661,127</b>
<b>Family/Consumer/Peer Support</b>		
Adult/Family Support - NAMI	CY 08	\$216,117
Adult/Family Support - WFT1	CY 08	\$276,000
Consumer/Peer Support - GEP	CY 08	\$454,000
<b>Subtotal</b>		<b>\$946,117</b>
<b>Systems Change</b>		
County QI/BP's Implementation (5 counties)	CY 08	\$351,847
Children's System Change - WFT1	CY 08	
Homeless Access to MH Services (Dept. of Commerce)	FFY 09	\$41,448
Infant Mental Health - WI AIMH (Children's Services Society)	FFY 09	\$20,000
Infant Mental Health - WI AIMH (Children's Services Society)	feb 09 - sep 09	\$51,000
MH/AODA Functional Screen - 5 counties	sep 08 - march 09	\$22,847
Promote Trauma Informed Systems - UW Board of Regents2	FFY 09	\$73,639
<b>Subtotal</b>		<b>\$560,781</b>

<b>Transformation Activities</b>		
CCS & CSP Development Training (7 counties)	CY 08	\$35,938
CCS Technical Assistance - UW Board of Regents2	FFY 09	
Case-Focused Education Service for Children - UW Board of Regents	FFY 09	\$50,281
Tribal Best Practices in Co-Occurring Disorders - Sokaogon Tribe	FFY 09	\$51,764
TA Resources for Providers, CM Serving Elders- Metastar County Systems Transformation Study - The Management Group (TMG)	FFY 09	\$23,000
	FFY 09	\$172,715
Milwaukee County Study - Public Policy Forum	Apr 09 - Sep 09	\$13,332
<b>Subtotal</b>		<b>\$347,030</b>
<b>Training</b>		
Children's & Crisis Training - WCCF	FFY 09	\$10,520
Children Come First Conference - WFT1	CY 08	
MH Consumer Reimbursement - GEP	CY 08	\$23,024
Elderly Mental Health Training - Greater WI Agency on Aging Resources	FFY 09	\$409
MH Teleconferences & Psych Consultation - UW Board of Regents2	FFY 09	
<b>Subtotal</b>		<b>\$33,953</b>
<b>Prevention, EI &amp; Recovery</b>		
Prevention/EI - MHA	FFY 09	\$74,489
Recovery Technical Assistance/Coord - UW Board of Regents2	FFY 09	
<b>Subtotal</b>		<b>\$74,489</b>
<b>Protection &amp; Advocacy</b>		
Protection & Advocacy - DRW	SFY 09	\$75,000
<b>Subtotal</b>		<b>\$75,000</b>
<b>NOMS Data Collection/Eval</b>		
MH Data Report Development - UW PHI	FFY 09	\$94,642
<b>Subtotal</b>		<b>\$94,642</b>
<b>State Operations</b>		
		\$600,149
<b>TOTAL</b>		<b>\$6,869,210</b>

1. Part of a large contract with Wisconsin Family Ties for which total expenditure is listed under "Adult/Family Support - WFT".
2. Part of a large contract with Board of Regents for which total expenditure is listed under "Promote Trauma Informed Systems".

**Itemized County Expenditures of Community Aids**

As a requirement for receiving the \$2,513,400 in Community Aids from the Mental Health Block Grant (MHBG), counties are responsible for reporting how they spend their allocation to the state. The counties' use of Community Aids funding is reported back to the state on a calendar year basis in the eight categories listed in Table 2. Due to the December 2009 deadline for submission of this report, the CY 2009 county expenditures of Community Aids funds are not available. Thus, the individual county figures listed in Tables 2 and 3 below are CY 2008 expenditures. Table 2 lists the specific county recipient of the Community Aids funds, a description of how each county spent their funds among the eight allowable categories, and the amount of the allocation as determined by the state's formula.

**Table 2 CY 2008 Actual Expenditures of Community Aids**

County	CY 2008 Allocations	Community Support Programs	Supported Housing	Jail Diversion	Crisis Intervention	Family, Consumer & Peer Support	Child/Adolescent Services	Dual Diagnosis Adults	Data Set Development	Comp Community Svcs	CY 2008 Actual Expenditures	Clients Served	Under Spending
Adams	\$8,555		\$155			\$8,400					\$8,555		\$0
Ashland	\$9,580		\$6,136					\$3,444			\$9,580		\$0
Barron	\$20,066				\$20,066						\$20,066		\$0
Bayfield	\$7,354	\$7,354									\$7,354		\$0
Brown	\$98,340	\$98,340									\$98,340		\$0
Buffalo	\$7,803			\$3,353				\$4,450			\$7,803		\$0
Burnett	\$7,248		\$5,000		\$2,248						\$7,248		\$0
Calumet	\$12,388		\$409				\$11,979				\$12,388		\$0
Chippewa	\$27,037	\$27,037									\$27,037		\$0
Clark	\$16,032	\$8,700			\$7,332						16,032.		\$0
Columbia	\$16,818	\$16,818									\$16,818		\$0
Crawford	\$7,939	\$7,939									\$7,939		\$0
Dane	\$160,098	\$23,800			\$71,298		\$65,000				\$160,098		\$0
Dodge	\$31,007	\$4,688	\$500				\$25,819				\$31,007		\$0
Door	\$7,665	\$5,018	\$840		\$472	\$266	\$776	\$293			\$7,665		\$0
Douglas	\$25,572	\$20,640			\$4,932						\$25,572		\$2
Dunn	\$18,754	\$8,000	\$1,115	\$500	\$3,639		\$5,000	\$500			\$18,754		\$0
Eau Claire	\$51,569	\$38,796			\$12,773						\$51,569		\$0
Florence	\$3,434				\$2,515	\$919					\$3,434		\$0
Fond du Lac	\$37,307	\$37,307									\$37,307		\$0
Forest/Vilas/	\$24,615		\$24,615								\$24,615		\$0





## **Programs Receiving Block Grant Funds in 2008-2009**

### **I. Family/Consumer/Peer Support**

#### ***Consumer, Self Help, Peer and Family Support Services***

Wisconsin embraces the value and practice that mental health services within the public mental health system must be consumer and/or family-driven, strength based and recovery-oriented. The contributions by and partnerships with mental health consumers and family members are essential to the transformation of the Mental Health (MH)/Alcohol and Substance Abuse (SA) systems. Statewide implementation efforts are striving to reach the goal of consumer and family member meaningful involvement at all levels of decision-making in policy development, planning, oversight, and evaluation. Leading efforts with internal partners toward goal attainment is the role of the Consumer Relations Coordinator. The Consumer Relations Coordinator (hired in 2006) brings widespread personal experience, knowledge of public and private mental health systems, recovery, and leadership experience. The overall position's goal is to assist in recruitment, training, and support of a wide variety of consumer partners. Some of the many other roles and responsibilities include: participating in internal DHS discussions as a key spokesperson; providing information and feedback regarding transformation of the systems; monitoring two consumer agency contracts; and partnering externally with individual consumers and groups to conduct trainings.

In addition, 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 Recovery Implementation 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 programs. All consumer participants are provided stipends and trainings, which offer training opportunities to build upon their leadership skills to enhance full participation as meaningful partners in this state level Recovery Implementation Task Force. The committees of the Recovery Implementation Task Force include inpatient recovery, evidence-based practices, peer support/peer specialist and transformation through Comprehensive Community Services (CCS).

#### ***Grassroots Empowerment Project (GEP)***

The state holds a strong value regarding peer support and peer provided services. The DMHSAS allocated MHBG funding to support consumer-run, peer support services and family support and education services in 2008. In 2008, the Grassroots Empowerment Project (GEP) was under contract with the DMHSAS, as Wisconsin's only statewide mental health consumer controlled organization. GEP provided technical assistance and support to 10 consumer run, peer support grantee sites in various areas of Wisconsin. GEP assisted their boards of directors with the long term goal of maximizing the likelihood of successful, locally controlled, sustainable, consumer run, peer alternatives in local communities. Five sites received funding from the GEP contract to develop "Recovery Centers" to provide more defined services for consumer members. Some programs employed paid consumers to provide services. In addition, the GEP promotes the process of inclusion for increasing consumer participation in the mental health service system at the local, state, and national levels for policy and program decision-making.

## **GEP 2008 Activities**

The independent non-profit organizations (Peer Sites) supported through the GEP consumer contract are at least 51 percent consumer controlled. The services that each organization provides are designed to bring the vision of hope, resiliency, empowerment and recovery to consumers of mental health services in their local areas. Services include but are not limited to peer support, education and skill development, individual and systems advocacy, outreach to underserved consumers, and building collaborative relationships with other providers of mental health services.

In 2008, GEP provided technical assistance to the Peer Sites in the following areas:

- Confidentiality
- Leadership Development
- By-law Development
- Program Development
- Board Development
- Grievance
- Fiscal Issues and Grant Writing
- Conflict Resolution
- Recovery
- Advocacy
- Non-Profit Management
- Business Plan Development
- Personnel Policy Development
- Peer Facilitation

Additionally, two Grantee meetings were held which offered training on: Cultural Competency, Business Plan Development, and Grant Writing. A Listening Session on trauma in the mental health service system and trauma informed care was also offered. Additionally, a Consumer Conference was held in 2008 and was attended by 210 Wisconsin mental health consumers. Topics presented at the conference included:

- Role of the Peer Specialist-Exploring Opportunities
- Basic Recovery Principles in Every Day living
- How to Support Peer Specialists in the Workforce
- Managing Your Own Recovery
- Ethics and Boundaries in Working with Peers
- Write Your Own Wellness Recovery Action Plan
- Understanding Mental Health and Substance Abuse
- Meaningful Participation in Person Centered Planning
- Trauma Informed Peer Support
- Overcoming Stigma and Building Self Esteem
- Using Motivational Interviewing to Enhance Recovery, Recovery in Your Own Voice

In 2008, Peer Sites provided:

- Direct services and supports to 1828 adults with mental illness
- 16,864 hours of peer support and related activities

- 19391 hours of work for 305 consumer volunteers
- Peer support via the telephone to 11,377 warm line callers

### ***National Alliance on Mental Illness (NAMI-Wisconsin)***

In FFY 2008, \$13,000 in MHBG funds were awarded to NAMI Wisconsin to continue their core recovery activities including web domain development and maintenance, a recovery newsletter (three issues per year), consumer summits (two per year) and some personnel costs. Additionally, NAMI-Wisconsin received \$210,000 in MHBG funds to provide support to adults and families with serious mental illness.

### **NAMI 2008 Activities**

NAMI Wisconsin expanded two of its signature programs, *Family-to-Family* and *In Our Own Voice* in 2008. A total of 22 new Family to Family teachers were trained during 2008 increasing the number of *Family to Family Education Program* (FFEP) teaching teams by 11. A total of 307 family members participate in NAMI's FFEP classes. The family members were from 13 different NAMI affiliates.

NAMI Wisconsin expanded the family education program to include NAMI Basics for young families. Training of five teacher teams occurred in September 2008, representing Dane, Portage, Wood, Fond du Lac, Milwaukee, Grant and Iowa counties. Eight family members attended NAMI Basics classes in Dane County. Two additional classes occurred in early 2009. The NAMI Basics Program is a six week course (15 total hours) taught by trained teachers who are also the parents or other caregivers of individuals who developed symptoms of mental illness prior to the age of 13.

A research study was conducted to evaluate the impact of the NAMI Basics course focusing on the following outcomes:

1. Parental stress in dealing with their child's illness, insurance, and providers;
2. Parental empowerment in getting information to better help their children, advocating for services, and dealing with their child's difficulties;
3. Parental self-care, meaning taking care of their emotional, physical, and psychological needs; and
4. Family problem solving and communication skills.

The study is being led by Dr. Barbara Burns, Duke University and Dr. Kimberly Hoagwood, Columbia University. All caregivers participating in the NAMI Basics Education Program in Tennessee and Mississippi were asked to participate in the study, which consisted of a pre-test, a post test, and a three month follow-up. The study was open to participants in all Basics classes taught in those two states between October 2008 and May 2009. The final report of the findings of the study, including conclusions and recommendations from Dr. Burns and Dr. Hoagwood, is expected in November 2009.

NAMI Wisconsin also utilized MHBG funds to hire Dr. Timothy Howell, a geropsychiatrist, for consultations and training on working with older individuals with mental illness in 2008.

### Disseminated Information

NAMI Wisconsin also distributed a Resource Binder to all 33 NAMI affiliates with information helpful to older persons and caregivers who are facing mental health issues. The Resource Binder includes contact information on Adult Resource Centers (ADRCs) and Area Agencies on Aging, facts about mental health, substance abuse and aging, overcoming barriers and community integration, dealing with stigma, and resource information.

The *Iris* newsletter was published four times during 2008. Copies were distributed in March/April, June/July, September/October, and the final 2008 issue in December. A total of 24,000 copies were distributed in total. The *Iris* is full of articles, online resources and information on mental health issues. Publications are sent to members, professionals, providers, policy makers, libraries and other interested parties.

NAMI Wisconsin also worked with Learfield Communications to develop five 60 second informational spots that can be broadcast over the radio. Two of the spots were broadcast through the Wisconsin Radio Network during one week in December 2008. The 60 second spots have people talking about their difficulties and how NAMI Wisconsin and its affiliates helped them. They also have the 60 second spots in MP3 format and will have them available to download on their website in 2009.

### Increased NAMI Wisconsin Membership

Additionally, NAMI Wisconsin funded additional affiliates at a cost of \$7,000. They provided new affiliates (Dodge, St. Croix Valley, Green County and Iron Counties) with \$500 non-competitive grants. With the remaining funding, \$500 grants were offered to rural affiliates that did not apply to the first round requests, including Barron, Door, Douglas, Jefferson, Manitowoc, Marinette/Menomonee, Portage/Wood, South Central Wisconsin and Walworth Counties.

The NAMI Wisconsin Consumer Council (NWCC) was formed in 2005. The NWCC is a standing committee of the NAMI Wisconsin Board of Directors and derives its organizational structure from the NAMI National Consumer Council. The NWCC holds consumer leadership summits and has an active, productive and influential membership. The NAMI Wisconsin Recovery Project maintains its own website and publishes the Recovery Newsletter, which is included in the *Iris*, NAMI Wisconsin's quarterly newsletter. Three issues of the Recovery Newsletter were published and disseminated during 2008. Each issue of the Recovery Newsletter was distributed as an insert to the *Iris*. Approximately 6,000 copies of each issue of the Recovery Newsletter were distributed for a total of 18,000 issues. In addition to sending the Newsletter to individuals, additional copies were disseminated to Wisconsin libraries and other relevant agencies. During 2008, the NAMI Wisconsin Consumer Council contributed articles to the Recovery Newsletter as well as other Wisconsin consumers. A total of 12 stipends were given to consumer reporters for articles that they wrote that were included in the Recovery newsletter.

Two Consumer Leadership Summits were held during 2008. The first was held on April 24, 2008 in Racine, Wisconsin. It was held in conjunction with the NAMI Wisconsin Annual Conference which occurred on April 25 and 26, 2008. A featured speaker at the summit was Lizzie Simon, author of

Detour-My Bipolar Road Trip in 4D. The summit was attended by 68 consumers.

### **III. Systems Change and Transformation**

#### **Prevention and Early Intervention**

##### ***Mental Health America of Wisconsin (MHA)***

Mental Health America of Wisconsin (MHA) is the lead contracted agency for MHBG-funded prevention and early intervention activities. The MHA receives approximately \$95,000 in MHBG funds annually. The MHA works with local school districts on suicide prevention projects. Technical assistance is provided in setting up the projects by providing direct guidance and resources from experts in the area of child suicide prevention such as the UCLA Center for Mental Health in Schools. The MHA offers educational opportunities to other school districts, mental health providers, and parents about youth suicide and school mental health through conference presentations and publications. Another priority area for the MHA is increasing screening for depression and other mental health disorders in primary care settings. MHA provides information and an annual symposium for primary care physicians and mental health professionals on integrating mental and physical health. Additionally, MHA offers a special web page on its site with information pertaining to primary care screening. Goals continue to promote education, information, and implementation models to physicians on how to screen, diagnose, and treat persons with mental health disorders within the primary care setting. Another goal is to bring medical administrators, health plan providers, consumers and healthcare providers together from across the state in creating buy-in and rationale for best practice comprehensive health service delivery. Goals continue to identify potential strategies and barriers for implementation and to identify key partners in planning future steps to implement best practices and strategies.

##### ***MHA 2008 Activities***

In 2008, MHA was involved in a number of initiatives across the state including:

- Implementing the Garrett Smith Youth Suicide Prevention Grant;
- Initiating the integration of primary care with mental health and substance abuse treatment;
- Working with Wisconsin United for Mental Health;
- Working with the Wisconsin Prevention Network;
- Involving the Child Welfare system with mental health initiatives; and
- Providing resources for child protective services and mental health workers as well as web-based resources for the state.

##### **Garrett Smith Youth Suicide Prevention Grant**

In 2008, MHA continued to implement all aspects of this grant. Some of the activities of the initiative included all-site tele-conferences and project site visits; all-site meetings (topics included sustainability of projects and review of evaluation instruments); training on "Assessing and Managing Suicide Risk"; attending Garrett Smith grantee meetings, training and consultation to non-project sites, trainings for community stakeholders; and dissemination of project information to the community and co-chairing the Suicide Prevention Initiative. All sites updated their work plans. Projects supported by funding through SAMSHA included evaluation of the Well Aware newsletter, development of a social marketing campaign, development of mini-

grants, and development of a Burden of Suicide report by the Medical College of Wisconsin (MCW) and the Division of Public Health.

Cross-site and local evaluation of project sites being implemented included:

- Training Exit Surveys completed for all training events,
- Product and Services Inventory completed quarterly,
- Second round of Community Infrastructure Surveys completed,
- Early identification, referral and follow-up surveys completed, and
- Training Utilization and Penetration Survey completed.

Additional Statewide Efforts:

- Disseminated project CDs and other resources.
- Expanded involvement with tribes through the State-Tribal Collaborative for Positive Change, the Bemidji Region of the Indian Health Services suicide prevention conference, and a youth suicide prevention conference sponsored by the Oneida Tribe of Indians of Wisconsin.
- Provided training and consultation to a number of non-project sites, including Dane County, Vernon County, Kenosha County, Altoona and Eau Claire Schools.
- Evaluated Well aware newsletter and planning for next steps in informational communications to schools.
- MHA staff continues to co-chair the Suicide Prevention Initiative and disseminate e-news.
- Began work on statewide strategic planning summit to be held in April 2009.

Additional special projects included:

- Held three regional meetings--Conducted a southeast regional training on Assessing and Managing Suicide Risk (AMSR) for 45 clinicians; a northern regional training which provided suicide prevention education and action planning and AMSR training for 55 clinicians; as well as a Chippewa Valley regional training attended by 400 people which included presentations by the Department of Public Instruction and clinicians.
- Completed scripting for American Sign Language of SOS video. Production planning is currently in process.
- Initiated social marketing project with Entercom Communications Corp. in southeast Wisconsin, in conjunction with Charles E. Kubly Foundation:
  - Web ads, cumulative impressions=916,312 (through mid-October); click through rates are 2-3 times national average; 1124 total click throughs
  - Streaming ads; 6,449 spots with 237,042 impressions
  - Public affairs shows
  - WSSP (sports radio) Interview
  - Podcasts in production
  - All materials created for on-air, on-line use can be found at: <http://wmyx.radiotown.com/mhawrecap/recap.html>
- Six Mini-grants were awarded through competitive application process in 2008:
  - Stockbridge-Munsee Band of Mohican Indians; QPR training and Native American Lifeskills implementation in schools.

- Dane County Safe Communities Coalitions; initial QPR training-of-trainer held in May, second training scheduled for October.
- School District of Janesville; QPR and AMSR trainings.
- Opportunities Inc./Delinquency Prevention Council of Jefferson County.; summit held Oct. 8, 2008, about 60 people attended for suicide prevention education and QPR training.
- School District of Antigo; working on revision of school policies and trainings.
- Training completed by Wisconsin Association for Homeless and Runaway services for about 30 workers on QPR and mental health issues in youth on Sept. 30, 2008; ongoing work with agencies to implement policies.

#### Burden of Suicide in Wisconsin

This report was released in September of 2008, during Suicide Prevention Awareness Week. (The link to the report is: <http://www.mhawisconsin.org/Uploads/prevention/bosfinal9.5.pdf>) It contains detailed data on suicide and suicide attempts by age, gender and other circumstances. County level reports are being produced on a regular basis until all are completed.

#### Primary Care Initiative

The MHA continues involvement in the Governor's Policy Committee for the Wisconsin Initiative to Promote Healthy Lifestyles. Meetings explored how to coordinate substance abuse screening efforts with the primary care initiative. Additionally, a meeting was held with the former Executive Director of the American Academy of Pediatrics/Wisconsin about how to work with the American Association of Pediatricians around children's mental health issues. Also, discussions with Aurora Medical Center were held regarding strategic planning on the integration of mental health and primary/acute care.

#### Wisconsin United for Mental Health (WUMH)

The MHA maintains an active role on the WUMH steering committee. Staff participated in the development of a successful grant application for the National Anti-Stigma Campaign. The MHA staff is involved in the Lt. Governor Barbara Lawton's Implementation Coalition for her Task Force on Women and Depression and the Mental Health Day of Action. Additionally, MHA staff worked on a presentation to the State Division of Public Health on progress on the mental health goals for Healthy Wisconsin 2010.

#### Wisconsin Prevention Network

MHA staff continues to be involved on the Board of the Wisconsin Prevention Network. MHA staff is involved in the State Council on Alcohol and Other Drug Abuse's Prevention Committee and its Underage Drinking subcommittee. In this capacity they are seeking to promote the understanding of the relationship between youth substance abuse, mental health issues and suicide.

#### Child Welfare

The MHA continues to expand both its Invisible Children's Program (ICP) and its new Family Center (through funding from the Children's Trust Fund). Both of these efforts intersect considerably with the child welfare system in Milwaukee. As a result of these initiatives, the MHA continues to enhance its expertise and stature with regard to the mental health needs of children and adults in the child welfare system. The MHA joined the Milwaukee Child Welfare Partnership for Professional Development's Foster and Adoptive Parent Training Advisory Committee. The MHA also received funding from the Children's Trust Fund for training that promotes effective parenting skills in families where mental health and substance abuse issues exist.

The MHA expanded mental health child welfare training to South Eastern region that includes Dane County. It provided three trainings in 2008. The MHA is also partnering with the Children's Service Society of Wisconsin to develop and support ICP-like services in Marathon and Rock counties. It submitted and received a Child Abuse and Neglect Prevention Grant for the project. The MHA will provide training, consultation, resources, and site support. The MHA also provided training on Empowering Families of Milwaukee and the Home Visitors program.

#### Resources

The MHA developed a parenting tool kit for case workers in child welfare and mental health. The tool kit includes recovery and crisis work plans for parents and their children and 12 parenting supplements related to parental mental illness. Supplements enhance regular parenting curricula such as the Nurturing Program. Tool kits can be used individually by case workers or in group settings. Tool kits will be available on-line. The MHA also supports a web site which is available to all 72 counties which is being expanded as new information is available. Approximately 5,000 individuals access the county information monthly.

#### Men Get Depression

MHA was selected as an outreach partner for a documentary on men and depression that was broadcast on public television. This was supported by funding other than the MHBG, but was a joint project between MHA and the Bureau of Prevention Treatment and Recovery. MHA sponsored a screening and panel discussion in May 2008, at the Discovery Center in Milwaukee and a webcast with DHS. Approximately 600 copies of the outreach DVD on men and depression have been distributed statewide.

Outreach grants were provided to five vendors around the state to educate stakeholders about men and depression:

- MHA Sheboygan presented at senior centers, reaching 195 older adults.
- Access to Independence in Madison presented information to persons with disabilities.
- Northeast Wisconsin Technical College presented a video called: "In Harm's Way: Suicide Intervention/Prevention for Public Safety Officers." Seventy people viewed the video as part of a two-day training.
- MHA presented information on men and depression to the organization "100 Black Men in Madison."

## **IV. Training**

### ***The Crisis Intervention Network***

In 2008, Crisis Intervention Network, numbered over 177 individuals representing all 72 counties. It was a group of stakeholders from across the state including DMHSAS staff, advocates, consumers, family members, and county providers. The Crisis Network remained actively involved in the promotion of certification for county crisis programs by offering technical assistance to develop county crisis programs, data collection regarding crisis care, measures of its effectiveness and utilization, and in the coordination of the annual Crisis Intervention Conference. The Crisis Network and the Crisis Conference both work to promote the enhancement of crisis intervention services in the community. The network developed a Best Practice model for better coordination between law enforcement and crisis services at the point of determining if an individual should be held in emergency detention and best disposition. Regional training sessions tailored to meet local needs were offered to promote this Best Practice

model 2008. (In August 2009, a law was passed in Wisconsin requiring law enforcement to work with crisis staff in all emergency detentions.)

The Network continued to meet quarterly in 2008. Information was exchanged regarding crisis intervention issues, i.e., stabilization, crisis beds, mobile crisis response, and suicide awareness and prevention strategies. Other information shared is in regard to suicide screening and risk for suicide, contracts and agreements, collaboration between agencies, and insurance and Medicaid billing issues.

### ***Regional Crisis Response System***

In response to the 2004 Request for Proposal for multi-county regional crisis intervention/stabilization program expansion, eight applications were received, of which, six were funded at \$100,000/year for up to five years. The purpose of these funds is to develop or expand crisis services using a multi-county/tribal agency approach. Due to the fact that many smaller counties do not have the resources for their own certified crisis stabilization program, the funds have been targeted for regional or multi-county projects so that counties can collaborate to meet their needs.

The funds are being used for the development and/or enhancement of crisis services in order to reduce hospital/institutional admissions. There is \$541,700 available per year of state GPR funds for this initiative. Funding for one additional Multi-County Crisis Program (Milwaukee/Waukesha) was made available in 2005. There are five funded regions in 2009-2010. Local savings from reduced hospital/institutional placements along with the Medicaid reimbursements would help to sustain the programs. As of 2008, 30 counties involved in the six Regional Multi-County Crisis Programs, 26 were certified under HFS 34 Subchapter III and eight more will become certified within two years.

### **Crisis Intervention Conference**

The 12<sup>th</sup> Annual Crisis Intervention Conference occurred in September 2008. It was attended by multiple system partners, such as law enforcement, county human services administrators and staff; CSP staff; teachers and administrators, health care providers; public and private mental health care providers; consumers; family members; and advocates. Attendance over the past three years has been 500 - 600 participants. The training takes place over one and a half days and conference hours apply to required on-going training for individuals providing certified mental health crisis services under HFS 34. Other required crisis training opportunities include supervision, consultation, and support are provided independently by each certified crisis program according to the standards set forth in HFS 34.

Topics presented in Keynote Addresses for the conference included:

- Is Forced Treatment an Oxymoron? Questions for Practice
- Kids in Crisis: Strategies for Unmasking Hidden Trauma Wounds
- Care and What Matters in the Recovery Process

Topics presented in the Breakout/Workshop Sessions for the conference included:

- Lessons Learned: Living With Serious Severe Mental Illness
- Teens Who Hurt: Effective Strategies for Working with Troubled Adolescents
- Crisis Intervention Collaboration with Law Enforcement and Mental Health
- Working with People that Don't Want to Work With Us

- Crisis Intervention with People with Personality Disorders
- Role of Peer Specialists and Their Value in Crisis Work
- The Psychiatric Emergency Assessment of the Geriatric Patient
- Crisis Work with Children and Adolescents After a Suicide Death
- Crisis Plans for Suicidal Youth
- Aging and Mental Health-We're All In This Together
- Rethinking the Risks for Violence
- Untangling Intangible Loss in Traumatized Children and Adolescents
- Working with People Who Cut
- Brain Injury Basics for Professionals
- Substance Use Disorders: Identification and Treatment in Adolescents
- Components of a Successful Peer Specialists Program
- Suicide Assessment Protocol-Trying to Satisfy Everyone
- Protective Factors: What Helps an Individual Stay Alive?
- Using Psychiatric Medicine in the Recovery Process: Helping Clients Work Through Decisional Uncertainty
- Crisis Assessment 101
- Psychiatric Advance Directives and Their Value in Crisis Work
- Community Based Diversion Options
- Valuing Recovery Principles In Inpatient and Community Settings
- Assessment of Imminent Risk for Suicidal Callers
- What You Can Do To Prevent Suicide in Youth
- PTSD & Readjustment Concerns of Returning OEF/OIF Veterans
- Cultural Competency

### ***Mental Health/Substance Abuse Needs of Older Adults and Associated Training***

#### ***Training for Mental Health Providers who Serve Older Adults***

Wisconsin has been moving forward with efforts to improve mental health and substance abuse services, through providing geriatric psychiatric expertise to local long term care programs who request it, with coordination by staff at DMHSAS. An important component of the DMHSAS planning work has been the development of the Wisconsin Geropsychiatry Initiative (WGPI). The WGPI began when a geropsychiatrist, Dr. Timothy Howell, initiated a collaborative with a group of persons interested in making geropsychiatric expertise available to community workers serving older persons with mental health/substance abuse needs. The group started meeting in 2004-2005 to refine and adopt an effective teaching model/method called the Star Method. In FFY 2005, the WGPI began providing indirect care to older persons via case-specific consultation by geropsychiatrists to long-term care, geriatric, and public agencies, primarily focused in the Milwaukee area. This WGPI initiative received an "Award for Educational Innovation," from the Annapolis Coalition on Behavioral Health Workforce Education in 2004.

In addition to the WGPI initiative, state staff continues to work with county agencies implementing a Comprehensive Community Services (CCS) program to ensure that this lifespan program serves older adults. The CCS benefit could be a significant source of Medicaid funding for older adults to use to access mental health and substance abuse services. One of the core requirements of a county CCS plan is outreach to all populations. This is of particular relevance to older adults with mental illness who self isolate. They are not responsive to the usual forms of outreach through newspapers, advertising in key locales in the community and booths at health

fairs. DMHSAS provided funding for outreach and treatment pilots in the 2008 plan, and teamed with the regional Aging Networks and local aging units funded by the Older Americans Act to pilot outreach mechanisms in both rural and urban regions for those elderly who were in need of treatment, but had not been diagnosed or treated for their mental illness because of stigma and self isolation.

The FFY 2008 plan for development of mental health/substance abuse services for older adults included:

- Partnering with state and local programs to fund increased consultations/training to local teams of providers who request geriatric psychiatry expertise and are serving older persons with MH/SA needs in various service systems;
- Partnering with health care clinics to provide and fund geriatric psychiatry expertise to primary care providers and teams serving older adults with complex cases (using the Star method in the WGPI);
- Partnering with MH/SA consumer initiatives to fund initial and ongoing consumer efforts to use sites frequented by older adults that are stigma free and accessible such as Senior Centers, to disseminate education and information about mental health and substance abuse to the older population;
- Developing and disseminating of web based geropsychiatric training modules, using evidence-based practices in connecting to and serving older adults, for use by case managers serving an older population;
- On-going development of a geropsychiatric infrastructure to better meet the mental health and substance abuse needs of older adults who receive all their care from primary care physicians and clinics. Including investigating linkages between the small planning group with a broader planning group or “Think Tank” to improve integrated services to older adults with MH/SA issues; and
- Developing outreach models in rural and urban environments that are designed to reach self-isolating older adults who may have mental health issues that are untreated.

### ***Psychiatric Consultation and Clinical Education/Training***

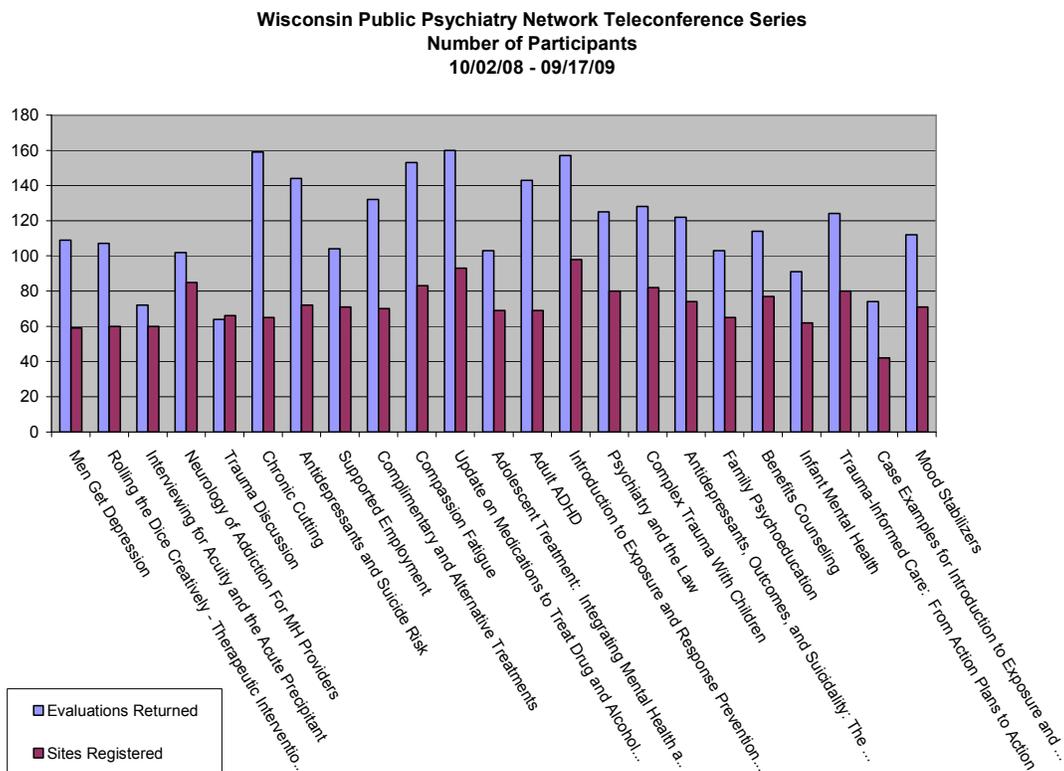
The Psychiatric Consultation and Clinical Education/Training project is a collaborative effort between the Bureau of Prevention Treatment and Recovery and the University of Wisconsin School of Medicine and Public Health, Department of Psychiatry. Mental health practitioners and other professionals and consumers around the state have access to up-to-date information on issues and topics. The goal of each teleconference is to increase the expertise of non-physician mental health professionals, especially in rural areas of the state where psychiatric time is limited. Over 100 agencies and 400-450 mental health professionals are estimated to take advantage of this learning opportunity each year and have received continuing education units. Written evaluations and verbal responses have indicated high support for the topics, quality of presentations, and usefulness of the presentations. Examples of topics have included Psychotherapy models, Postpartum Depression, Consultation, Gero and Child psychiatry and Stigma.

The Bureau of Prevention Treatment and Recovery funds the Wisconsin Public Psychiatry Network Teleconference Series provided through staff support from the University of Wisconsin Department of Psychiatry; the 2008-09 series included a variety of topics presented by speakers in the field. Twenty-four biweekly teleconference training sessions were provided as of September 2009. Outcomes for the year include an average of 80 sites from across the state

registering for each teleconference with an average of 100 professionals and consumers participating in each teleconference. Evaluation scores indicate that 97 percent of the participants rate the importance of topic as good or excellent, 93 percent of the participants rate the Quality of Presentation as good or excellent, 97 percent expect the trainings to benefit consumers, and 92 percent expect to use the information gained from the trainings.

See Table 7 below for Wisconsin Public Psychiatric Network Teleconference Series number of participants:

**Table 7:**



## V. Protection and Advocacy

### *Disability Rights Wisconsin (DRW)*

Wisconsin’s protection and advocacy agency is Disability Rights Wisconsin (DRW), which receives funding directly from the federal Center for Mental Health Services and from the MHBG through the Division of Mental Health and Substance Abuse Services (DMHSAS). The DRW is mandated to protect and advocate for the rights of individuals with mental illness and their families, and to investigate reports of abuse and neglect in facilities or community programs that

provide care or treatment for 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. 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 mental illness, stigma, recovery, recovery-oriented services, trauma informed services, and access to appropriate services.

In 2008, DRW focused its goals and resources on furthering the concepts of consumer empowerment, recovery and stigma reduction, on protecting and enhancing consumer rights, including access to services, in community treatment and support programs, and on addressing issues related to trauma and to persons with mental illness who are in the criminal justice system. In 2008, DRW received an increase of \$10,000 in MHBG funds for a total of \$75,000 for the federal fiscal year. DRW added additional activities with the increase in funds including:

- Providing direct advocacy assistance for an increased number of consumers who are experiencing rights violations in community treatment programs and difficulty in accessing community services (including persons on probation/parole); and
- Providing one or more additional Guided Reflections trainings on Implementation on Recovery Concepts.

### ***DRW 2008 Activities***

1. Patient rights protection in community treatment programs and reduction of stigma due to discrimination were supported by providing peer and self advocacy training and individual advocacy assistance.
2. The booklet: "Where to Now? A field guide to resolving complaints within the mental health system" was reprinted.
3. Direct advocacy assistance to consumers who were experiencing rights violations in community treatment programs and difficulty in accessing community services (including persons on probation/parole) was provided.
4. Work with the Bureau of Prevention Treatment and Recovery (BPTR), the Recovery Implementation Risk Force, and the peer support committee was continued. Training on recovery concepts was provided as requested.
5. DWR worked with BPTR to provide input into the revision of the outpatient rules. DWR advocated for the inclusion of recovery concepts, such as consumer collaboration and informed consent into the rules.
6. DRW provided staff to operate the Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health. The committee focused on improving mental health services in county jails and on reintegration of offenders, with a special emphasis on collaboration between community mental health and substance abuse services and corrections programs.
7. DRW worked with BPTR, consumers, mental health, substance abuse, sexual assault and domestic violence service providers and others on improving services for persons who have mental health problems and a history of trauma. This included participation with the New Partnerships for Women Project, as well as making presentations on the relationships between mental health, substance abuse, and trauma. DRW worked with the Department of Health Services and DMHSAS to develop plans and strategies across the Department for improving services to this population.

8. DRW took an active role in promoting consumer and family involvement and activities to eliminate discrimination and stigma against persons with mental illness. They participated in Wisconsin United for Mental Health and coordinated activities with the Milwaukee Task Force on Mental Health.
9. DRW collaborated closely with existing consumer organizations including: Grassroots Empowerment Project Inc. (GEP), National Alliance on Mental Illness-Wisconsin (NAMI), Mental Health Association of America (MHA), Wisconsin Family Ties (WFT), and the Mental Health Council to develop coordinated positions and to strengthen the consumer and family movements in Wisconsin. This included participation on the Council's Legislative and Policy Committee.

### ***Independent Living Centers (ILCs)***

Eight Centers for Independent Living 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.

The impact of center services reaches thousands of Wisconsin citizens with disabilities and their families each year. Services developed are also unique. Some of the services below are available only through the ILCs, and in rural counties, ILCs are the only for all of the services listed below. Highlights of the impacts of those services are:

- **Employment**--The majority of ILC boards and staff, including decision-making staff, are persons with disabilities. In 2008, there were 202 people with disabilities employed at the ILCs. In addition to the staff, the ILCs provided employment services to 1,628 people with disabilities.
- **Benefits**--As a result of being employed at the ILCs, 11 percent of the employees no longer on public benefits. The ILCs provided services to an additional 3,324 people with disabilities that assisted them in reducing or eliminating their public benefits.
- **Community Integration**--Wisconsin ILCs play a key role in helping individuals with, either leaving costly institutions, or preventing their placement in institutions. During 2008, ILCs assisted nearly 3,000 Wisconsin citizens who either left expensive institutional settings or were assisted with prevention of entering institutions for a net Medical Assistance savings in excess of \$24 million. The following services were provided in 2008:
  - 2,981 were assisted with locating housing.
  - 2,048 were assisted with accessing transportation.
  - 16,444 received Information and Referral Services.
  - 1,389 received Independent Living Skills Training.

- 569 received Peer Support.
- 2,567 received Individual Advocacy Services.

### ***Wisconsin Council on Mental Health Criminal Justice Committee (MHCJ Committee)***

Disability Rights Wisconsin, (DRW), provides staff support to the Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health, which met eight times during 2008. In addition to representation from DRW, the Committee has representation from the Wisconsin Department of Corrections (Psychiatric, Psychology, Juvenile Corrections, Jail Liaison and Administration), the Department of Health Services, the Social Security Administration (State Liaison), the Wisconsin Counties Association, the Wisconsin Counties Human Services Association, the Wisconsin Sheriff's Association, the State Department of Commerce, Mental Health Consumer Advocates, Mental Health Providers, and State Legislators.

A work group developed under the MHCJ Committee substantially improved communications between many Wisconsin's jails, the Social Security Administration (SSA) and inmates with mental illness. The work group improved the availability of monetary and medical benefits to persons with mental illness in the process of reentering the community from Wisconsin jails. The group addressed an issue this population faces on re-entry. Often the SSA does not know an individual receiving Social Security Income (SSI) is incarcerated and continue monthly disbursements that must be returned to the SSA by law. When the individual is released he must forfeit the over-paid benefit income to the SSA compromising his/her ability to transition back into society. The Committee improved communications by creating a process that notifies the SSA when an individual qualified for SSI is being released. This allows benefits to be reinstated quickly. Five regional meetings with jail administrators and sheriffs were arranged around the state to spread the concept to the 62 county jails.

**A Prisoner Re-Entry Employment Workgroup** was also organized in 2008 under the Committee with representation from the Social Security Administration (SSA), Department of Corrections (DOC), NAMI (National Alliance for the Mentally Ill-Wisconsin), the Wisconsin Department of Vocational Rehabilitation (DVR), the Wisconsin Department of Health Services (DHS) (Division of Mental Health and Substance Abuse Services), the Department of Workforce Development (DWD), the Grassroots Empowerment Project Inc. (GEP), and the Wisconsin Mental Health Council (MHC). A key part of successful re-entry is employment. This time-limited work group was formed to identify employment related programs available to this population and to coordinate these programs with the DOC to improve availability of services. The work group met several times and generated meaningful MOU's between Departments to better accomplish coordination. This work group continued well into 2009.

The MHCJ Committee is presently engaged in discussions to identify the unmet needs of persons with mental illness in Wisconsin's jails. The discussions include the necessity of conducting a data driven "needs analysis" to formulate recommendations to meet those needs and then to work toward implementation of those recommendations. Representation from the counties, jail administrators and sheriffs are participating in these discussions. The goal is that mental health services in jails across the State will benefit from the eventual outcome.

Wisconsin was one of four states selected by the "Council for State Governments" in 2009 to participate in the Chief Justice Criminal Justice/ Mental Health Initiative. The Wisconsin Court's Chief Justice will chair a task force to address the most important issues the state faces in its

Criminal Justice System regarding its population of persons with mental illness. The MHCJ Committee has been asked to assist this task force by recommending issues the Task Force should consider addressing during 2010. The Committee will be working with the Chief Justice's Office in developing recommendations as the Task Force mission is developed.

A few years ago the Committee developed a series of recommendations on ways to improve re-entry for persons with mental illness leaving State prisons. These recommendations were approved by the Wisconsin Council on Mental Health and were forwarded to the Secretaries of the Department of Corrections and the Department of Health Services. A meeting was held with both Secretaries and their staffs to present the recommendations and receive their comments regarding implementation. The Committee has identified re-entry from both county jails and state prisons along with jail mental health services as priorities for the near term.

## **VI. System Change and Transformation Activities**

### ***Comprehensive Community Services Benefit***

The 2003-2005 state budget included authorization to expand the scope of psychosocial rehabilitation services that may be offered in Wisconsin under the Medicaid (MA) program. A new psycho-social rehabilitation program known as the Comprehensive Community Services benefit (CCS) was designed in a collaborative effort between the Divisions of Mental Health and Substance Abuse and Health Care Access and Accountability working together with the advisory workgroup membership which included consumers, family members, county staff, advocates and Mental Health Council members.

#### Overview

Comprehensive Community Services (CCS) benefits complement those provided by existing CSPs by offering a flexible array of services to a broader group of consumers than CSPs serve. CCS programs emphasize a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to children, adults and older adults whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by CSPs. CCS programs are designed to serve consumers across the lifespan who experience functional deficits as the result of mental health and/or substance related disorders. The number of consumers who are served varies from county to county, depending upon a variety of factors, the greatest of which is likely the make up of the general population of the county.

#### CCS Start-Up Grants

Starting in 2006, the DMHSAS began providing start-up funds for counties to establish new CCS programs. The DMHSAS used State funding originally intended as start-up funds for CSPs and mental health block grant funds. Start-up funds are used to provide training regarding the provision of recovery-based services, system transformation and development of ongoing quality improvement activities. Start-up funds are also used to provide reimbursement for consumers involved in the coordination committee's participation in the development of the CCS program. Additionally, start-up funds also support a temporary increase in staff time available to do program development activities needed to prepare an application for certification of the CCS program.

These one-year grants focus upon the completion of outcomes that guide the counties or tribes through the tasks and decision-making activities necessary for the system change to support CCS program development and a recovery-oriented system. Some examples of

transformational requirements of CCS include: a coordinating (advisory) committee with significant consumer involvement; development of an integrated mental health and substance abuse service array to provide comprehensive services across the lifespan; recovery-based, person-centered assessment and service planning processes; staff training in recovery principles; and consumer focused outcomes and quality improvement initiatives. Certified CCS programs may be partially funded by MA with the county providing the non-federal share. These programs may also coordinate with other existing funding sources and other agencies that are involved with a consumer.

#### Certified CCS Programs

As of November 2009, 29 counties have received certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to counties toward development of CCS or CSP programs.

#### ***Person-Centered Planning***

The Wisconsin Department of Health Services was awarded a one year grant (the "CMS Real Choice Award") to bring recovery based, Person-Centered Planning (PCP) to the state's community-based mental health programs beginning in 2008. A precursor to this grant was a previously awarded grant to implement quality assurance for recovery-based, evidence-based practices (EBP) under the Comprehensive Community Services (CCS) statute. Technical assistance for the initiative was provided by the National Technical Assistance Collaborative (NTAC) which is part of the National Association of Mental Health Program Directors (NASMHPD).

Five counties initially applied for CCS and implemented the components of CCS. The five counties were then selected by the Bureau of Prevention Treatment and Recovery (BPTR) to be offered two full-days and three months of on-going technical assistance via follow-up phone calls on person-centered planning (PCP) as part of the NTAC consultation. Each of these counties use the Mental Health Functional Screen in their programs and agreed to use the SAMHSA Recovery Oriented Systems Inventory (ROSI) for surveying consumer satisfaction, prior to and after applying the PCP approach.

The Division of Quality Assurance and the Division Health Care Access and Accountability also participated in the training sessions to ensure that PCP would be integrated into the regulatory and reimbursement environment in Wisconsin.

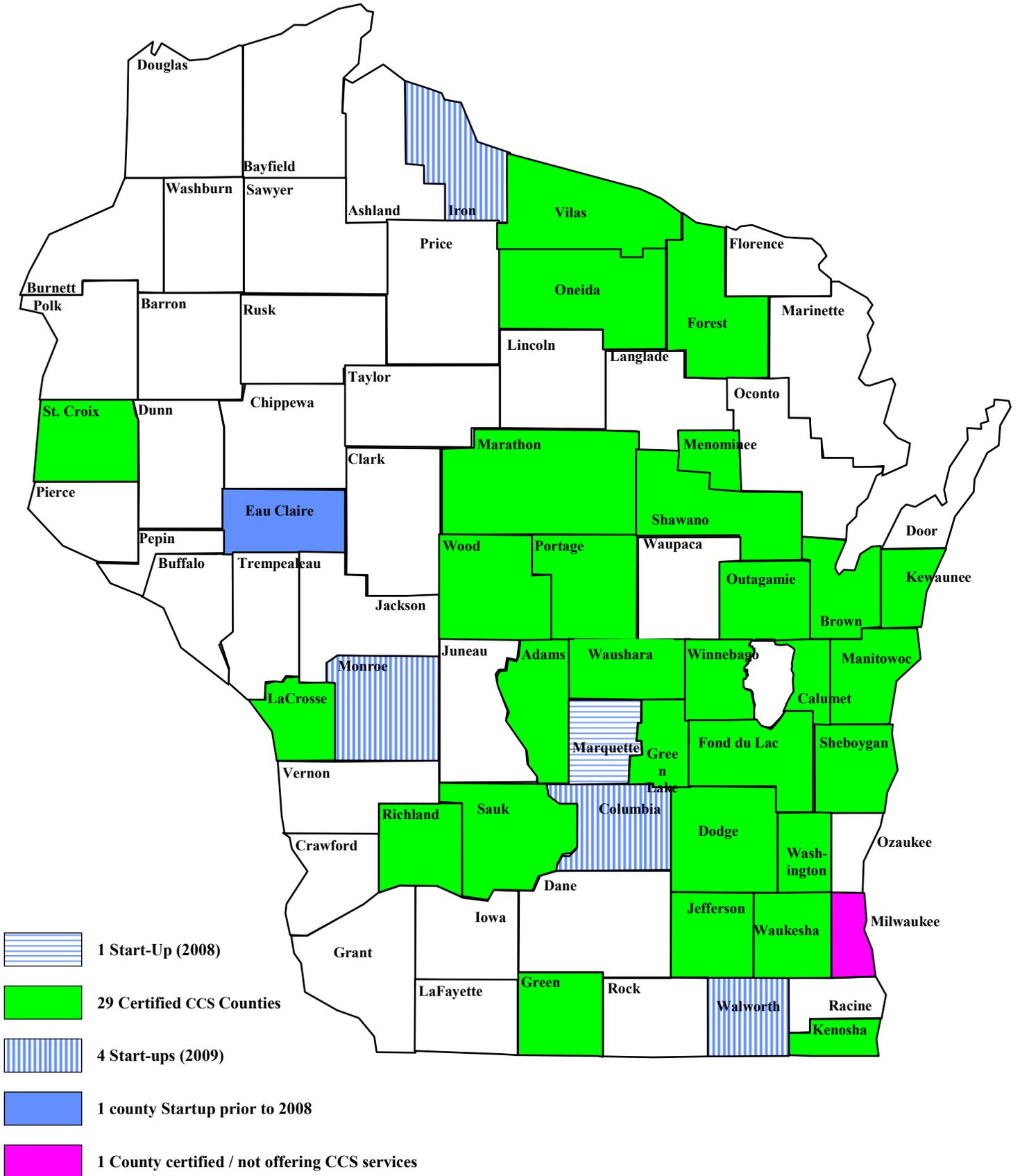
A national behavioral health consulting group, Alipar Inc., facilitated these training sessions and follow-up calls. In preparation for the bi-weekly teleconferences, each county team took turns preparing an Assessment, a Narrative Summary and a Person-Centered Plan of a consumer actively engaged in their mental health program. The documents were e-mailed to each of the other counties prior to the scheduled teleconference. The focus of the teleconference was on the use of PCP with its emphasis on the person's assessed strengths, central theme of the person and their states of change. The focus on the person-centered plan was on the use of the person's own

goals, strengths, objectives, and interventions applied by the providers this process proved to be beneficial in the development of new skill sets. As a whole, the group determined defining objectives (as opposed to goals and interventions) was the most difficult part in the formation of the person-centered plan.

Together, these two approaches PCP and implementation of Evidence-Based Practices (EBP) are expected to enhance the service array and enhance a person-centered approach currently being offered by these five existing community-based mental health programs. Each of these counties will be at a strategic advantage toward demonstrating a recovery-oriented, evidence-based, person-centered model of delivery. (Below are counties that have CCS programs that have been trained in person-centered planning.)

# COMPREHENSIVE COMMUNITY SERVICES (CCS) PROGRAMS

## June, 2009



## ***Trauma Informed Care Initiative***

On May 31, 2007, the Department of Health Services (DHS) held its first Trauma Summit, attended by over 80 representatives from each division in DHS, treatment partners, county human service providers, consumer advocacy groups, clients, and their families. A 44-page Trauma Summit summary report was written which included a list of recommendations to move Wisconsin forward in the area of trauma informed care.

Per the Trauma Summit work groups' recommendations, the Trauma Coordinator was hired to collaborate with consumers and other mental health and substance abuse systems' stakeholders in the planning, development and implementation of action steps outlined in the Trauma Summit summary report. The Trauma Coordinator created a Trauma Informed Care Advisory Board to provide advice and guidance in the implementation of the following action steps:

- Evaluating Wisconsin's current mental health and substance abuse trauma informed care;
- Increasing community awareness of trauma informed services and related issues;
- Identifying and seeking funding to support Wisconsin's efforts to increase the community's access to trauma informed services;
- Creating training and educational opportunities for community members and service providers;
- Promoting agency policies and practices that are trauma informed;
- Fostering trauma informed care collaborations (e.g., list serve, discussion boards, meetings, etc.); and
- Providing technical assistance and/or creating mentoring programs for agencies undergoing the implementation of trauma informed services.

The Trauma Coordinator started the "Implementation of Trauma-Informed Care Initiative" beginning in April 2008. The purpose of the initiative is to transform mental health and substance abuse services to be trauma-sensitive. The initiative incorporates an understanding of trauma's impact, including the consequences and the conditions that enhance healing in all aspects of service delivery. Additionally, the initiative will provide assistance services in making specific administrative and service-level modifications in practices, activities, and settings in order to be responsive to the needs and strengths of people who have life experiences of trauma. Additionally, the service systems will be educated about trauma-specific services which address the impact of trauma and facilitate trauma recovery.

The targeted population for the initiative is the public mental health and substance abuse service system, including: consumers, service providers, administration, and other stakeholders. Listening sessions regarding the issue were held in 2008 for five groups (total of 220 individuals) of program providers administrators. Additionally, four groups (total of 53 individuals) of consumers attended listening sessions.

Additionally, in December 2008, the Division of Mental Health and Substance Abuse (DMHSAS) received \$221,000 Transformation Transfer Initiative grant issued by NASHMPD. The grant is being utilized to facilitate the implementation of Trauma-Informed Care (TIC) within the public mental health and substance abuse services in the following ways:

- Hiring a Trauma Services Coordinator.
- Hiring a public relations firm to create a marketing strategy for the dissemination of Trauma Informed Care information.
- Providing statewide TIC Conferences.
- Identifying and providing initial training for 150 Trauma Care Champions representing Wisconsin's human service systems.
- Developing a Trauma-Informed Care Advisory Board which will hold six meetings.
- Planning and implementing three Trauma-Informed Care (TIC) special projects including: 1. A Menominee Law Enforcement and Judicial TIC training; 2. A Lac Courte Orielles event established to address historical trauma; and 3. TIC/Criminal Justice consultants to advise Wisconsin Resource Center in planning a TIC women's facility.
- Training DMHSAS staff in TIC.

## Evidence-Based Practices (EBP)

The BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the bureau. A variety of definitions of EBPs and EBP categorizations exist in the field, including such schemes as distinguishing EBPs from Best Practices and Promising Practices. The work group focused part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs helped Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. An outgrowth of the EBP work group has been the collection of utilization data on EBPs through the Community Support Programs (CSP) survey, which is administered annually by BPTR.

### *Evidence-Based Practices tracked through the Community Support Program Survey in 2008 (Need updated info. from Tim Wong)*

Each year an electronic survey is sent to each Community Support Program (CSP). The survey collects data on the number of clients at the beginning and ending of a given year, along with the number of admissions and discharges. In 2007, several data elements were added to the survey. Programs were asked to provide the reason for client discharges from the program and final disposition. Programs were also asked to provide the number of clients being served with the following seven evidence-based practices (EBP): 1) assertive community treatment (ACT), 2) co-occurring disorders, 3) family psycho education, 4) illness management and recovery, 5) medication management, 6) supported employment, and 7) supported housing. Programs were also asked if they were using NAMI Wisconsin's family-to-family programs. The following utilization rates of evidence-based practices for over 2,000 out of a total of 6,748 adult consumers were reported through the CSP Monitoring Report for 2007:

<b>Adults with Serious Mental Illness (SMI) in CSP 2007</b>							
	Receiving Supported Housing	Receiving Supported Employment	Receiving ACT	Receiving Family Psychoed.	Receiving IDDT	Receiving Illness Self Mngt.	Receiving Med. Mngt.
<b>Age</b>							
18-20	5	12	42	6	9	26	14
21-64	1054	564	4291	355	882	2171	2003
65-74	49	24	238	16	10	92	90

75+	6	0	61	5	1	16	21
Not Avail.	187	13	237	40	292	195	259
<b>Total</b>	1301	613	4869	422	1194	2110	2387

***County Quality Indicators for Evidence-Based Practices Initiatives***

Work continues on a number of transformation pilot activities that include developing a quality improvement (QI) process and implementing EBPs for Comprehensive Community Services (CCS) and Community Support Programs (CSP). These pilots are supported by the MHBG and numbers of clients receiving EBPs through the initiatives are tracked through the CSP survey. Counties will continue to collaborate with the Department to develop a comprehensive quality improvement program for community programs based on data driven measurement of quality indicators and consumer outcomes. This will assure cost effective consumer-based services at the local level. Agencies are required to identify a Quality Team that steers their QI efforts, use the Recovery Oriented Systems Assessment (ROSA) tool to evaluate their intake and assessment processes, to ensure they are recovery-oriented, use data to inform their quality improvement system, and implement an evidence-based practice. In addition they are encouraged to use a standardized consumer survey such as the Recovery Oriented Systems Inventory (ROSI) to identify systems issues around recovery. (See map below for counties with CSPs in 2008.)

As part of the pilot projects, Wisconsin began implementation of Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) in the five counties awarded contracts. Three counties are implementing IDDT and two counties are implementing IMR. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation. Marathon, Brown, Kenosha, Richland and Jefferson counties each received \$59,000 grants for this purpose in 2007. The EBP grants were also awarded in 2008 to help counties continue their implementation and quality improvement work.

The BPTR runs the EBP grants in three-year cycles. This is a core part of the Wisconsin transformation plan. Each county is required to compete for funding and they are required to do three activities. The activities include rewriting their forms, policies and procedures for intake into their community programs to ensure their system is consumer and family driven; implement a QI team for on-going TQI, using a data-driven typology promoted by the Department for all QI efforts; and implement at least one evidence-based practice in their community programs beyond ACT. All of these activities are required to be sustainable after the three-year cycle of funding is ended. In 2008, three of the counties will enter their last year of funding, and two counties were entering their second year of funding. These counties are becoming the experts in implementing their chosen EBP and will be used as mentors within their region as part of the BPTR plan for dissemination.

# COMMUNITY SUPPORT PROGRAMS (CSPs)

July, 2008



There are 78 certified Community Support Programs in the State of Wisconsin. The following counties have a joint CSP: Barron and Washburn; Forest, Oneida and Vilas; Grant and Iowa. The following counties have more than one CSP: Brown (2); Dane (5); Marathon (2); Milwaukee (11); Price (2); Rock (2); Winnebago (2).

## **VII. Services to Address Individuals who are Homeless, Hard of Hearing or Deaf, Older Adults or Veterans**

### ***Projects for Assistance in Transition from Homelessness***

In 2008, Projects for Assistance in Transition from Homelessness (PATH) funding continued to be administered through The Department of Commerce, Division of Housing and Community Development, Bureau of Supportive Housing. A Memorandum of Understanding between DHS and the Department of Commerce contained assurances that DHS will continue to provide mental health and substance abuse services for individuals who are homeless.

Individuals who are homeless and have SMI may be very difficult to engage so the primary focus for PATH funded programs is outreach, engagement, and connection to the full array of "mainstream" services available in a community. Because of the nature of homelessness, consumers need a wide range of different services plus housing. The essential services provided with PATH funding include outreach, screening and diagnostic treatment, community mental health services, case management, alcohol or drug treatment, habilitation and rehabilitation, supportive and supervisory services in residential settings, and referrals to other needed services. Programs can also use PATH money to fund limited housing assistance such as security deposits or one-time rent payments to prevent eviction. All of the PATH funded programs use a "housing first" approach encouraged by advocacy groups and validated by research. With the help of the HUD funding, PATH participants choose their housing first, and then receive other supportive services.

For FFY 2008 – 2009, the federal Projects for Assistance in Transition from Homelessness (PATH), administered by the Department of Commerce, provided funding to five programs in areas of the state with some of the largest populations of people who have SMI and are homeless. These programs included: Health Care for the Homeless, serving Milwaukee County; Tellurian, UCAN, serving Dane County; Rock County Human Services, serving Rock County; the Emergency Shelter of the Fox Valley, serving Outagamie County and Hebron House of Hospitality in Waukesha County. These agencies had contact with 2846 individuals who were homeless and had severe mental illness. Assistance was provided to over 2000 individuals.

PATH funds were also used to provide training on the Social Security application process. The majority of individuals who have serious severe mental illness and are homeless are likely to be eligible for Supplemental Social Security benefits and Medical Assistance; however the complex process of assembling the materials needed for a disability determination and the tendency of individuals not to stay in one place very long often impedes the application process. Approval of an application is rare.

PATH funds, combined with Mental Health Block Grant funds, (\$74,000 for 2008) were provided to four agencies to expand the SSI/SSDI Outreach, Access and Recovery program. The program currently in place in Waukesha Co. has proven to be very successful, with a success rate of approval of benefits for over 90 percent of the applicants on the first submission.

During the last six months of 2008, the funded agency in the Chippewa Falls area assisted 16 people with the SSI/SSDI application process. Of those 10 were successful in getting SSI/SSDI benefits. Included were back payments totaling \$46,728. Also, sixty days of back medical bills were paid. The LaCrosse area grantee hosted SOAR training and in 2009 began assisting clients

in submitting successful applications. In addition, Health Care for the Homeless in Milwaukee assisted with the submission of 12 applications and all 12 were successful.

With grants made available through PATH funds and Mental Health Block Grant funds, Hebron House of Hospitality and Health Care for the Homeless Milwaukee developed SOAR training teams who attended national training and became qualified to teach service providers to utilize the SOAR model to assist their clients in applying for SSI/SSDI. In 2008, approximately 150 people were trained to implement the SOAR model in their communities. These trainings are continuing in 2009.

In April of 2009, SOAR grants were also given to agencies in Rock and Outagamie Counties to increase the area where SOAR services are offered.

The Department of Commerce staff along with the SOAR grantees understand the necessity of developing a state-wide infrastructure that not only supports quicker determinations as well as some presumptive eligibility across the state, but can provide the financial resources to fund multiple agencies throughout the state to continue this much needed service. It is hoped that through the development of a SOAR Program Task Force, which will convene for the first time at the upcoming Wisconsin PATH Conference, these objectives can be accomplished.

PATH funds continue to be used for trauma training for people who work with persons who are homeless. People who have been traumatized live in a “sea of intense emotions” and their environment doesn’t teach them how to regulate those emotions. Behaviors such as cutting, drug and alcohol use, and reckless sex are attempts to regulate painful emotions. While these behaviors temporarily numb the pain, they also lead to more problems, including homelessness.

Trauma training helps workers understand the need to build trust and rapport with homeless individuals, and to proceed at a pace that is comfortable for the consumer. Workers need to realize that contact may occur in the street or in shelters for some time before the individual expresses an interest in additional services. With training, the workers are able to offer a “trauma-informed” approach to services and to be more effective in working with homeless persons.

PATH funds are also used to hold an annual Wisconsin PATH Conference. Over 50 service providers representing five PATH-funded and more than 20 non-PATH-funded agencies attended the 2008 conference. The keynote speaker for the event was a nationally known speaker who provided comprehensive two-day training on topics including outreach and engagement, motivational interviewing, supervision, and personal and organizational wellness.

For FFY 2009-2010, the federal Substance Abuse and Mental Health System Administration awarded \$784,000 in Projects for Assistance in the Transition to Homeless (PATH) to Wisconsin. The funds were awarded through a Request for Proposal (RFP) process. The five prior grantees were awarded new contracts and two new applicants were awarded grants. This will increase the area covered by PATH to include Racine and Brown Counties.

### ***Other Efforts to Serve Persons who are Homeless with a SMI***

In addition to PATH, the Department of Commerce’s HUD funded homeless programs provide a wide range of shelter and services. The Tenant-Based Rental Assistance Program (TBRA) assists clients with rent and utility assistance for up to 18 months. As match for this program, agencies must agree to provide support services to those served. Though individuals who are homeless and mentally ill are just one of the target populations that grantees can serve through TBRA, it

appears to be the primary focus for most of the nine agencies funded by the Department of Commerce with these HOME funds.

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 2009 to determine the number of people without housing on a given night. 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.

### ***Waukesha Jail Diversion Program--October 1, 2007 through September 30, 2008***

An additional program provided through the Waukesha County Department of Health and Human Services provided the following support and services to mentally ill individuals who are homeless or incarcerated, with the assistance of the Mental Health Block Grant Funds for the homeless for the period of time noted above. The following services and activities were provided through the Waukesha Jail diversion Program in FFY 2008:

- Total number of clients screened within the jail for transitional services: 338  
(Screening included inquiries regarding housing, mental health history, history of SSI application and referral for assistance in application if appropriate, referral for post incarceration transitional service, psychiatric follow-up, medication, and case management, IV drug usage/drug or alcohol history.)
- Total number of screened clients in the jail who reported as being homeless upon release: 327
- Total number of clients receiving transitional services after release from jail: 96  
(Includes: Housing assistance, SSI assistance if appropriate, Case Management, Protective payee services if appropriate, Counseling, Psychiatric/Nursing Services and Medication.)
- Total number of clients receiving psychiatric follow-up: 62
- Total number of clients receiving medication through the department's patient assistance program: 51
- Total number of clients who were helped with housing and sheltering: 144
- Total number of clients helped with SSI applications: 61
- Total number of clients receiving protective payee services: 19
- Developed jail contact tracking template.

### ***Services for Deaf and Hard of Hearing Persons with Mental Illness***

Beginning in January 2003, a Mental Health Specialist for Deaf and Hard of Hearing Services was working 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. The plan focused on how to provide culturally competent, culturally affirmative treatment services utilizing assistive devices and other communications technology. Specific activities included:

- Developing, funding and implementing a Deaf Crisis Intervention Team;
- Developing tele-health policies that are culturally affirmative, culturally competent, and linguistically appropriate for deaf and hard of hearing consumers;

- Developing Mental Health Interpreter training programs;
- Developing, funding, and implementing a Deaf Mental Health Advocate position;
- Issuing and analyzing the results of a Mental Health and Substance Abuse Provider Survey regarding services to Deaf and Hard of Hearing consumers;
- Issuing and analyzing the results of a Mental Health and Substance Abuse Survey to Deaf and Hard of Hearing consumers regarding service needs and gaps;
- Funding and implementing a Deaf Mental Health Advisory Committee;
- Increasing access to all appropriate mental health programming that meet the needs of Deaf and Hard of Hearing consumers, that are culturally affirmative, culturally competent and linguistically appropriate; and
- Continuing training activities on mental health issues, services, stigma and related issues to agencies, providers, counties, and members of the deaf community including stigma reduction training.

Unfortunately, in 2009, the DMHSAS Mental Health Specialist for Deaf and Hard of Hearing Services staff position was cut due to state budget constraints. The above activities are currently not being implemented at the state level. This population continues to lack adequate access to services in Wisconsin.

### ***Serving Older Adults with Mental Illness***

There are a number of programs for older adults being piloted in Wisconsin with the support of private, local state and federal agencies. Psychiatric morbidity continues to be high in the elderly populations served by these programs, but geriatric mental health resources remain scarce. Mobilizing geropsychiatry professionals to devote some of their time to providing indirect care through evidence-based consultation/teaching and to supporting other providers on an on-going basis, may help meet some of the growing needs. The responses of most care providers continue to be quite positive, and the Wisconsin Geriatric Psychiatric Initiative (WGPI) has made significant strides toward becoming self-sustaining.

Geropsychiatry professionals based in Madison and Milwaukee have participated in five types of activities since 2002, as part of a 10-year project to enhance geropsychiatric services:

1. Talks covering evidence-based approaches to treating depression, suicide assessment, as well as addressing delirium and dementia;
2. Consultation/teaching, which utilizes the Wisconsin Star Method of psychiatric, differential diagnosis and treatment;
3. Discussing challenging cases in a colloquium format, with feedback and support for team members;
4. Consultation and discussion regarding higher-level systems issues; and
5. Advocacy.

**DMHSAS Staff, Resources and Efforts**--In addition to this financial support from the mental health block grant funding, DMHSAS is dedicating staff time to improving access to housing and mental health services for homeless people by working with staff from the Bureau of Aging and Disability Resources to include the mental health population as a target group served in Aging and Disability Resource Centers (ADRC) for the following services:

- Information and assistance
- Referral to services (basic needs and mental health services)

- Access to the disability benefit specialist

### ***Aging and Disability Resource Centers***

Wisconsin is investing heavily in Aging and Disability Resource Centers (ADRC), which offer the general public a single entry point for information and assistance on issues affecting older people and people with disabilities (including mental illness), or their families. In 2008, there were eighteen ADRCs operating, including two regional ADRCs for rural areas (serving 3 counties each). There is a plan to go statewide by 2010. ADRCs are required by contract to provide three services to persons with mental illness: information and assistance, emergency response and the services of a disability benefit specialist. The Division of Mental Health and Substance Abuse Services provided technical assistance to ADRCs on outreach planning to mental health populations, including the homeless, and how to make linkages to agencies providing services and supports to people with mental health issues. The Division produced three training web-casts during 2007-2008 to ensure that ADRC staff is better equipped to deal with the population who have mental health issues and their families. In 2008, BPTR presented workshops to ADRC staff at the Bureau's annual conference to ensure ADRC staff understood the functional eligibility for Wisconsin Mental Health programs and how to access them through referrals to their local mental health agencies.

A benefit specialist can be accessed through ADRC's by people with mental health issues. The state requires that ADRC's serve individuals with mental illness by the third year of their contract, to ensure that they have the time to train staff and build up their required resource data base. ADRC's have strong linkages with the local economic support units at each county, so access to assistance in filling out applications for medical assistance as well as disability determinations has improved. Locations of the current ADRC's are available at:  
<http://dhfs.wisconsin.gov/LTCare/generalinfo/adrcmap.pdf>

### ***Services for Returning Veterans***

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 state's 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 Wisconsin's statewide recovery network.

The DMHSAS continues to support joint planning together 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 the two will continue to focus on the development of tele-medicine. The DMHSAS and Regional Area Administration Offices of DHS are informing counties of the availability of these services and communicating to providers the special needs of returning veterans.

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

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**Children's Plan**

**Part D. Implementation Report**

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## ***Section I. Narrative Content of the Implementation Report***

### **1. Summary of Areas Previously Identified by State as Needing Improvement-- Children**

**Directions:** Report summary of areas which the State identified in the prior FY's approved Plan as needing improvement.

#### **The State data collection system for children's mental health outcomes needs to be improved.**

It is the intent of Division of Mental Health and Substance Abuse Services (DMHSAS) to move towards an outcome-based, consumer-focused system where quality improvement is built into the programs at the local level. To that end, DMHSAS is developing mechanisms to collect outcome data and quality indicators and intend to change the way in which the division evaluates the success of services and supports provided. The DMHSAS has developed a functional screen that local agencies can use to develop indicators from so that quality improvement efforts can be data driven. The Division has also developed a consumer outcomes measurement tool, the Recovery-Oriented System Assessment (ROSA) tool, which we can use in a variety of ways: such as a teaching tool; a measurement tool; an assessment adjunct; and a peer review mechanism. This QI effort has begun in five counties and will be offered to an expanding number of counties in the coming year to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance.

#### **There exists a shortage of Medicaid dental providers that will serve mental health consumers.**

Medicaid is a federal/state program that pays health care providers to deliver essential health care and long-term care services to frail elderly, people with disabilities, and low-income families with dependent children, and pregnant women. Without Medicaid, these consumers would be unable to receive essential services or would receive uncompensated care.

Access to dental services continues to be a problem for Medicaid recipients in the state. Many dental providers choose not to serve Medicaid and other indigent patients many of whom have mental health issues. Dental care services were given increased focus during contract negotiations with certain Health Maintenance Organizations (HMOs) which cover dental services in order to increase access to those services. Dentists continue to push for increased Medicaid reimbursement rates. As of March 2003, dentists do not need to receive prior authorization for some dental procedures (i.e., root canals) for recipients under the age of 21. For children/youth that have Severe Emotional Disturbance (SED) and may be on psychotropic medications, a lack of dental care could have serious side effects. Poor dental care affects children's nutrition, growth, development, and well-being. Lack of dental providers willing to serve persons with mental illness, SED or persons who receive Medicaid is a problem across the country and Wisconsin. Policy makers, case managers and advocates continue to fight for better dental coverage for these populations.

## **There is a lack of mental health parity in Wisconsin.**

Parity legislation for mental health and substance abuse has yet to be enacted by the Wisconsin Legislature. In 2004, the state enacted Senate Bill 71, which prevents insurance companies from counting prescription drugs and lab testing against minimum coverage requirements for mental health services. This ensures that the full amount of minimum coverage will be available for mental health and substance abuse services.

A companion piece of legislation, Senate Bill 72, was introduced in the Governor's budget in both 2005 and 2007, but it was removed by the legislative Joint Finance Committee on both occasions because it was deemed to be a policy item. This bill would have raised minimum coverage requirements for mental health services. The minimum requirements would have been raised by an amount equal to the amount of inflation since the minimums were last adjusted 15 years ago. In 2007, SB375 was introduced for comprehensive parity bill (unlike the bills of the prior two sessions which only increased the mandated minimums). This bill passed the Senate Committee on Health and Human Services but was never brought to the floor for a vote. A companion bill was introduced in the Assembly late in the session. The session ended before this bill could be acted on in 2007.

Parity recently was passed at the federal level under the Emergency Economic Stabilization Act of 2008. Under the Act, parity will:

- End insurance discrimination against mental health and substance use disorder benefits for over 113 million Americans, requiring full parity coverage with physical health benefits.
- Extend to all aspects of plan coverage, including day/visit limits, dollar limits, coinsurance, copayments, deductibles and out-of-pocket maximums.
- Preserve strong state parity and consumer protection laws while extending parity protection to 82 million more people who cannot be protected by state laws.
- Ensure parity coverage for both in-network and out-of-network services.

It is unclear how this federal law will affect parity policy in Wisconsin.

## **Coordination of services for consumers with multiple needs to be improved.**

Although coordination efforts are increasing, collaborative efforts between state agencies to serve consumers with multiple agency needs is still a gap in the mental health service system. Consumers still must too frequently deal with uncoordinated services provided by different programs to address their multiple needs. As a result, duplication of services may occur or services are poorly planned due to the lack of coordination between agencies. Opportunities for leadership in planning collaborative initiatives and facilitating collaboration among local providers still exist. The Comprehensive Community Services (CCS) initiative will provide an opportunity to begin collaborative efforts with the ability to fund integrated mental health and substance abuse treatment.

## **Mentally ill homeless adults are still underserved in Wisconsin.**

Despite the benefits the Projects for Assistance in Transition from Homelessness (PATH) initiative may bring, a great need to serve individuals who are homeless with a serious mental illness remains. For FFY 2006, PATH funded four programs in areas of the state with some of the largest populations of people who have Serious Mental Illness (SMI) and are homeless. These

programs included: Health Care for the Homeless, serving Milwaukee County; Tellurian, UCAN, serving Dane County; Rock County Human Services, serving Rock County; and the Emergency Shelter of the Fox Valley, serving Outagamie County, and provided outreach to 1,280 individuals and enrolled 915 individuals in services.

Additional homeless individuals are served through counties and private agencies as mentioned above, but the priority given to serving homeless individuals is inconsistent among these other agencies. Homeless individuals can be difficult to serve due to their transient status and may sometimes receive a low priority for receiving mental health services. Many individuals who are homeless have both substance abuse disorders and serious mental illness. An estimated 50 percent of adults with SMI who are homeless have co-occurring mental health and substance abuse disorders. Additional needs for individuals who are homeless with a serious mental illness include screening, assessment, and integrated treatment for co-occurring mental health and substance abuse disorders.

### **There is a continuing shortage of psychiatrists/psychologists for children and adolescents.**

Wisconsin is one of many states that have a shortage of Child and Adolescent Psychiatrists (C/A Psychiatrists) available to treat young people with mental health disorders. According to a 2006 report by Christopher R. Thomas, M.D. and Charles E. Holzer III, Ph.D Wisconsin, while near the average, was still one of 35 states with less than the national average of C/A Psychiatrists for its youth population. The modeled number of psychiatrists for optimum care was reported as 14.38 per 100,000 youths. Wisconsin was reported to have 8.2 per 100,000. Having more C/A Psychiatrists is critical to providing the best mental health services to Wisconsin youth.

### **Not every county in Wisconsin has a certified crisis program.**

One of the weaknesses in the child system is the lack of certified crisis services in every county in Wisconsin. Certified crisis services would provide professional staff and support services both at the level of on-call and direct one-on-one response, 24 hours a day, seven days a week, to serve client and family needs. In addition, mobile crisis teams, with consumer/family participation, need to be able to provide effective diversion from hospitalization or incarceration when the crisis situation warrants it and suitable alternatives exist.

### **Not every county in Wisconsin has a Collaborative System of Care Initiative.**

The expansion of children's mental health services has been a long-standing goal of the Wisconsin Council on Mental Health (WCMH), parents, providers, advocates, and the Department. Collaborative systems of care such as Coordinated Services Teams (CST), Integrated Services Projects (ISP), and Comprehensive Community Services (CCS) have been established in over half of the counties in the state, but there are still many counties that lack the coordinated wraparound approach these initiatives offer for children and families' mental health needs. The Bureau of Prevention Treatment and Recovery is working with current initiatives to emphasize the need for sustainability after MHBG funding for their projects end, so that the funds may be freed up to provide seed money for projects in new counties.

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

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**Children's Plan**

**Part D. Implementation Report**

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## ***Section I. Narrative Content of the Implementation Report***

### **2. Most Significant Events that Impacted the State Mental Health System in the Previous FY--Children**

**Directions:** Report summary of the most significant events that impacted the mental health system of the State in the previous FY.

#### **Expansion of Supplemental Security Income (SSI) Managed Care**

Medicaid managed care for Supplemental Security Income (SSI) recipients continues to expand across the state as a way to fund flexible mental health and physical health benefits in Wisconsin, using a number of HMOs familiar with the Wisconsin system of care.

Since 2003, Wisconsin has been expanding SSI managed care across the state to adults receiving SSI benefits that are living in the community to, include persons with mental illness. Currently, the Medicaid (MS) SSI managed care program in Wisconsin covers 34 counties (11 added in 2008) serving over 11,000 individuals in Milwaukee and Southeast Wisconsin. Features of the MA SSI managed care program include:

- moderation of the initial risk with capitation and symmetrical risk sharing;
- exclusion of Medicaid clients who participate in Home and Community-Based waivers;
- a carve-out of all county non-federal share mental health services (Crisis Intervention, CSP, Targeted Case Management, and CCS) and other mental health services that may be in the scope of managed care contracts with or without risk;
- assurance that Managed Care Organizations (MCOs) contract with providers who can treat consumers with complex needs, e.g., persons with co-occurring substance abuse and mental illness as well as trauma survivors, and involve consumers in their treatment;
- inclusion of recovery principles and the RESPECT model in the contract and require/encourage partnerships between agencies serving adults with disabilities and medical managed care experience; and
- implementation a quality monitoring system with the purpose to detect and solve problems with HMO performance in a timely and ongoing manner.

Enrollment models for SSI managed care include an "All-in Opt-out" (applies to counties with two or more HMOs) and a "Voluntary" model.

As of March 1, 2008, the SSI managed care expanded into the following counties: Taylor, Clark, Marathon, Wood, Langlade, Menomonee, Oconto, Shawano, Waushara, Marquette, and Green Lake.

"All-in Opt-out" counties prior to March 2008 include: Milwaukee, Waukesha, Racine, Kenosha, Washington, Ozaukee, Dodge, Jefferson, Manitowoc, Fond du Lac, Sheboygan, Waupaca, Winnebago, Brown, Rock Outagamie and Calumet. Voluntary counties prior to March 2008 include: La Crosse, Trempealeau, Monroe, Buffalo, Jackson, and Vernon.

Stakeholders continue to be involved in SSI managed care. Advisory committees have been formed in each region with SSI managed care. The SSI Milwaukee/Southeast Managed Care

Advisory Committee developed quality indicators to assess the efficacy of the different managed care organizations and reports have been developed with results for each indicator.

### **Contract Safeguards**

In addition to an in-depth evaluation of the provider network as a condition of certification, the contract contains the following provisions to ensure continuity of care:

- The HMO must authorize and cover services with the enrollee's current providers for the first 60 days of enrollment or until the first of the month following the completion of the assessment and care plan.
- The HMO must honor Fee-For-Service (FFS) prior authorizations at the level approved under FFS for 60 days or until the month following the HMOs completion of the assessment and care plan.

### **Contract Requirements for Care Management:**

- A comprehensive assessment and the development of a care plan for each enrollee.
- The HMO must submit a monthly detailed report of assessments to the Department.
- The HMO must conduct patient status and care plan review and updates as medically indicated, but at least annually as part of monitoring both clinical and non-clinical standards of care.

### **Expansion of BadgerCare Plus**

The expansion of BadgerCare Plus extends coverage for basic health insurance to a population that was not served previously, including people with mental health and substance abuse services needs. BadgerCare Plus merged Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families. In addition to the existing Family Medicaid categories, BadgerCare Plus will provide health care coverage to:

- All children (birth to age 19) with incomes above 185% Federal Poverty Level (FPL)
- Pregnant women with incomes between 185% and 300% FPL
- Parents with incomes between 185% and 200% FPL
- Caretaker relatives with incomes between 44% and 200% FPL
- Parents with children in foster care who have income up to 200% FPL
- Young adults aging out of foster care
- Farmers and other self-employed parents with incomes up to 200% FPL (contingent on depreciation calculations).

### **Medicaid Preferred Drug List (PDL)**

To control costs and provide clinically sound drug therapy for recipients, the Wisconsin Division of Health Care Access and Accountability maintains a PDL and supplemental rebate program for Wisconsin Medicaid, BadgerCare and SeniorCare. Preferred Drug List recommendations are made to the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee based on the therapeutic significance of individual drugs and the cost-effectiveness and supplemental rebates with drug manufacturers. Drugs included on the PDL are recommended to the PA Advisory Committee based on research from peer-reviewed medical literature, drug studies and trials, and clinical information prepared by clinical pharmacists. A previous Secretary of DHS,

Helene Nelson, formed a Mental Health Drug Advisors Group made up of mental health consumers, family members, psychiatrists and advocates to advise her on the cost, availability and efficacy of mental health drugs.

### **Children's Long-Term Care Waiver**

The 2003-2005 biennial budget included funding to continue the ongoing development of the Long-Term Care Redesign initiative for children with special health care needs including children with severe emotional disturbances. The 2005-2007 biennial budget proposed to continue it. 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.

The waivers address the needs of children who meet different federal target groups, including physical disabilities, serious emotional disturbance (SED) and developmental disabilities. 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 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 rather than hospital or institutional placements.

As of December 1, 2009, there were 329 children waiting for intensive in-home autism services through the CLTS Waivers. There are 670 children currently receiving the intensive in-home autism services through the CLTS Waivers. There are 1263 children that transitioned from the intensive in-home autism services to the on-going services in the CLTS Waivers. There are 1057 children receiving services through locally matched waivers, 58 children in pilot slots, 88 children in crisis slots and 415 children in special state-funded slots. There are a total 3551 children receiving services through the CLTS Waivers.

### **Shortage of Psychiatric Providers for Child and Adolescent Psychiatrists**

Wisconsin is one of many states that have a shortage of Child and Adolescent Psychiatrists (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 2006, Christopher R. Thomas, M.D. and Charles E. Holzer III, Ph.D provided an extensive report on the continuing shortage. In the author's report, Wisconsin with 112 C/A Psychiatrists was near the national average of C/A Psychiatrists. Wisconsin, while near average, was still one of 35 states with less than the national average of C/A Psychiatrists for its youth population. The optimum of C/A Psychiatrists for effective care was reported as 14.38 per 100,000 youths. Wisconsin was reported to have 8.2 per 100,000. Having more C/A Psychiatrists is critical to providing the best 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.

Available C/A Psychiatrists often practice in larger metropolitan areas leaving many of Wisconsin rural areas with even fewer C/A Psychiatrists than are necessary for even rudimentary care. The lack of insurance parity for mental health contributes to this problem.

## **Children's Mental Health Screening Pilots within Child Welfare**

In August of 2007, the Division of Mental Health and Substance Abuse Services (DMHSAS), in conjunction with the Division of Children and Family Services (DCFS), awarded seed money to 10 counties to test the process of screening for mental health and substance abuse issues for children coming into the child protective services (CPS) system. The results of the pilot for children flagged by the screen as needing further assessment were below the expected average compared to national statistics. There were several contributing factors; the wording on the screen was too severe, some workers did not appear well informed on the impact of trauma on children and their mental health, etc. Further funding in the future is anticipated, and training will be updated to better address the impact of trauma. The new pilot will target five counties in the northeast region of the state.

## **Joint Statement on "The Integration of Physical Health, Mental Health, Substance Use, and Addiction"**

On January 12, 2009, Secretary Timberlake issued a letter supporting the Department's joint statement on "The Integration of Physical Health, Mental Health, Substance Use, and Addiction." Secretary Timberlake stated that within DHS, a joint statement and actions steps were created to "bridge illness prevention and management, health promotion, public education and awareness efforts." She stated that the goal is to improve the lives of Wisconsin's citizens, "leading people of all ages, from all families and communities to optimal physical, mental, social, emotional, and spiritual health." The Joint Statement, Endorsement Form, and Action Step Objectives are located on the Department website at <http://dhs.wisconsin.gov/mentalhealth/jointstatement/index.htm>

## **Program of Assertive Community Treatment--Pilot Addressing Adolescents Day Treatment**

The Program of Assertive Community Treatment (PACT) of Mendota Mental Health Institute developed the Assertive Community Treatment Model, which is one of six evidence-based practices promoted for replication by the Center for Mental Health Services. PACT is a multi-disciplinary mental health staff organized as an accountable, mobile team, to provide comprehensive treatment, rehabilitation, crisis, and support services. PACT also provides the evidence-based practices of supported employment, integrated substance abuse/mental health treatment, and illness management, as well as integrated health care. PACT serves as a training center for assertive community treatment for mental health practitioners from Wisconsin, the United States and the world.

For the last several years, PACT has been engaged in a research project to evaluate the impact of early intervention with adolescents. The purpose of the project has been to define standards for ACT teams that serve adolescents with severe and difficult to treat mental disorders that are in need of transition services.

Due to the demonstrated success of ACT services in reducing hospitalization and improving the quality of life for adults with severe and persistent mental illness, there has been interest in adapting the ACT model for these most ill youth. If the benefits of ACT services for adults, including decreased hospitalization, transfer to adolescents, expected outcomes would include improved school functioning, lowered family burden, and a smoother transition into adulthood.

In 1998, the PACT Program of Mendota Mental Health Institute in Madison, Wisconsin made these adaptations: The PACT Youth Transition Project initiated providing services for youth ages 15-18 in 1998 and is still admitting youth under the transition protocol. The results to date are encouraging, with a reduction of hospital days, (Ahrens, Frey, Knoedler, and Senn-Burke, 2007) and an excellent rate of high school completion and transition to work.

**County Responsibility for Non Federal Share Inpatient Costs of State Mental Health Institutes**

Beginning January 2010, counties will be responsible for paying the non federal share of the costs for inpatient stays for children and older adults at the state mental health institutes.

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

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**Children's Plan**

**Part D. Implementation Report**

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**Section I. Narrative Content of the Implementation Report**

**3. Purpose State FY BG Expended-Recipients - Activities Description--Children**

**Directions:** A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

**Expenditure Report**

**Overall FFY 2009 Mental Health Block Grant Expenditures/Allocations**

**Table 1  
FFY 2009 MHBG Expenditures by Program Area**

<b>Title</b>	<b>Time Period</b>	<b>Expenditures</b>
<b>Community Aids for all counties</b>	CY 08	\$2,475,922
<b>Children's MH Programs</b>		
ISP	CY 08	\$1,306,700
CST (7 Counties)	FFY 09	\$183,312
CST TA (Waupaca County)	FFY 09	\$119,351
CST (2 Tribes)	FFY 09	\$51,764
<b>Subtotal</b>		<b>\$1,661,127</b>
<b>Family/Consumer/Peer Support</b>		
Adult/Family Support - NAMI	CY 08	\$216,117
Adult/Family Support - WFT1	CY 08	\$276,000
Consumer/Peer Support - GEP	CY 08	\$454,000
<b>Subtotal</b>		<b>\$946,117</b>
<b>Systems Change</b>		
County QI/BP's Implementation (5 counties)	CY 08	\$351,847
Children's System Change - WFT1	CY 08	
Homeless Access to MH Services (Dept. of Commerce)	FFY 09	\$41,448
Infant Mental Health - WI AIMH (Children's Services Society)	FFY 09	\$20,000
Infant Mental Health - WI AIMH (Children's Services Society)	feb 09 - sep 09	\$51,000
MH/AODA Functional Screen - 5 counties	sep 08 - march 09	\$22,847
Promote Trauma Informed Systems - UW Board of Regents2	FFY 09	\$73,639
<b>Subtotal</b>		<b>\$560,781</b>
<b>Transformation Activities</b>		

CCS & CSP Development Training (7 counties)	CY 08	\$35,938
CCS Technical Assistance - UW Board of Regents2	FFY 09	
Case-Focused Education Service for Children - UW Board of Regents	FFY 09	\$50,281
Tribal Best Practices in Co-Occurring Disorders - Sokaogon Tribe	FFY 09	\$51,764
TA Resources for Providers, CM Serving Elders- Metastar County Systems Transformation Study - The Management Group (TMG)	FFY 09	\$23,000
	FFY 09	\$172,715
Milwaukee County Study - Public Policy Forum	Apr 09 - Sep 09	\$13,332
<b>Subtotal</b>		<b>\$347,030</b>
<b>Training</b>		
Children's & Crisis Training - WCCF	FFY 09	\$10,520
Children Come First Conference - WFT1	CY 08	
MH Consumer Reimbursement - GEP	CY 08	\$23,024
Elderly Mental Health Training - Greater WI Agency on Aging Resources	FFY 09	\$409
MH Teleconferences & Psych Consultation - UW Board of Regents2	FFY 09	
<b>Subtotal</b>		<b>\$33,953</b>
<b>Prevention, EI &amp; Recovery</b>		
Prevention/EI - MHA	FFY 09	\$74,489
Recovery Technical Assistance/Coord - UW Board of Regents2	FFY 09	
<b>Subtotal</b>		<b>\$74,489</b>
<b>Protection &amp; Advocacy</b>		
Protection & Advocacy - DRW	SFY 09	\$75,000
<b>Subtotal</b>		<b>\$75,000</b>
<b>NOMS Data Collection/Eval</b>		
MH Data Report Development - UW PHI	FFY 09	\$94,642
<b>Subtotal</b>		<b>\$94,642</b>
<b>State Operations</b>		<b>\$600,149</b>
<b>TOTAL</b>		<b>\$6,869,210</b>

1. Part of a large contract with Wisconsin Family Ties for which total expenditure is listed under "Adult/Family Support - WFT".
2. Part of a large contract with Board of Regents for which total expenditure is listed under "Promote Trauma Informed Systems".

### **Itemized County Expenditures of Community Aids**

As a requirement for receiving the \$2,513,400 in Community Aids from the Mental Health Block Grant (MHBG), counties are responsible for reporting how they spend their allocation to the state. The counties' use of Community Aids funding is reported back to the state on a calendar year basis in the eight categories listed in Table 2. Due to the December 2009 deadline for submission of this report, the CY 2009 county expenditures of Community Aids funds are not available. Thus, the individual county figures listed in Tables 2 and 3 below are CY 2008 expenditures. Table 2 lists the specific county recipient of the Community Aids funds, a description of how each county spent their funds among the eight allowable categories, and the amount of the allocation as determined by the state's formula.

**Table 2 CY 2008 Actual Expenditures of Community Aids**

County	CY 2008 Allocations	Community Support Programs	Supported Housing	Jail Diversion	Crisis Intervention	Family, Consumer & Peer Support	Child/Adolescent Services	Dual Diagnosis Adults	Data Set Development	Comp Community Svcs	CY 2008 Actual Expenditures	Clients Served	Under Spending
Adams	\$8,555		\$155			\$8,400					\$8,555		\$0
Ashland	\$9,580		\$6,136					\$3,444			\$9,580		\$0
Barron	\$20,066				\$20,066						\$20,066		\$0
Bayfield	\$7,354	\$7,354									\$7,354		\$0
Brown	\$98,340	\$98,340									\$98,340		\$0
Buffalo	\$7,803			\$3,353				\$4,450			\$7,803		\$0
Burnett	\$7,248		\$5,000		\$2,248						\$7,248		\$0
Calumet	\$12,388		\$409				\$11,979				\$12,388		\$0
Chippewa	\$27,037	\$27,037									\$27,037		\$0
Clark	\$16,032	\$8,700			\$7,332						16,032.		\$0
Columbia	\$16,818	\$16,818									\$16,818		\$0
Crawford	\$7,939	\$7,939									\$7,939		\$0
Dane	\$160,098	\$23,800			\$71,298		\$65,000				\$160,098		\$0
Dodge	\$31,007	\$4,688	\$500				\$25,819				\$31,007		\$0
Door	\$7,665	\$5,018	\$840		\$472	\$266	\$776	\$293			\$7,665		\$0
Douglas	\$25,572	\$20,640			\$4,932						\$25,572		\$2
Dunn	\$18,754	\$8,000	\$1,115	\$500	\$3,639		\$5,000	\$500			\$18,754		\$0
Eau Claire	\$51,569	\$38,796			\$12,773						\$51,569		\$0
Florence	\$3,434				\$2,515	\$919					\$3,434		\$0
Fond du Lac	\$37,307	\$37,307									\$37,307		\$0
Forest/Vilas/	\$24,615		\$24,615								\$24,615		\$0



**Table 2 CY 2008 Actual Expenditures of Community Aids**

Richland	\$9,465	\$5,800					\$3,665					\$9,465		\$0
Rock	\$73,312						\$73,312					\$73,312		\$0
Rusk	\$9,661					\$9,661						\$9,661		\$0
Sauk	\$17,541	\$12,317					\$5,224					\$17,541		\$0
Sawyer	\$8,146					\$213						\$213		\$0
Shawano	\$16,604					\$16,604						\$16,604		\$0
Sheboygan	\$51,197						\$51,197					\$51,197		\$0
St. Croix	\$17,529	\$17,529										\$17,529		\$0
Taylor	\$9,043						\$9,243					\$9,243		
Trempealeau	\$15,769	\$15,769										\$15,769		
Vernon	\$12,392	\$12,392										\$12,392		\$0
Walworth	\$22,005	\$11,002				\$11,003						\$22,005		\$0
Washburn	\$8,386					\$8,386						\$8,386		\$0
Washington	\$37,470	\$37,470										\$37,470		\$0
Waukesha	\$109,469	\$38,816	\$20,222			\$24,000	\$26,431					\$109,469		\$0
Waupaca	\$20,786	\$20,786										\$20,786		\$0
Waushara	\$10,433						\$10,433					\$10,433		\$0
Winnebago	\$68,961	\$68,961										\$68,961		\$0
Wood	\$39,193	\$16,264				\$22,929						\$39,193		\$0
<b>TOTAL</b>	<b>\$2,513,400</b>	<b>\$1,350,511</b>	<b>\$204,871</b>	<b>\$26,830</b>	<b>\$314,959</b>	<b>\$9,885</b>	<b>\$541,513</b>	<b>\$42,618</b>	<b>\$3,671</b>	<b>\$10,450</b>	<b>\$2,475,922</b>	<b>\$0</b>	<b>98.51%</b>	<b>0.00%</b>
<b>Percent of Total Allocation</b>		<b>53.73%</b>	<b>8.15%</b>	<b>1.07%</b>	<b>12.53%</b>	<b>0.39%</b>	<b>21.55%</b>	<b>1.70%</b>	<b>0.15%</b>	<b>0.42%</b>	<b>98.51%</b>	<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>

## **Programs Receiving Block Grant Funds in 2008-2009**

### **I. Children's Mental Health Programs**

#### **Wisconsin's Collaborative Systems of Care**

Wisconsin's Collaborative Systems of Care go by many names such as Coordinated Service Teams (CST), Wraparound, Integrated Service Projects (ISP), Comprehensive Community Services (CCS) and Children Come First. These are all approaches that respond to individuals and families with multiple, often serious needs in the least-restrictive setting possible. Collaborative systems of care are not a specific set of services; rather they are a series of processes based on family and community values that are unconditional in their commitment to creatively address needs. Creative services are developed by a person-centered team that support normalized, community-based options. Each team develops an individualized plan, which incorporates strengths of the participant and team to address needs. Participants are equal partners and have ultimate ownership of the plan.

Wisconsin has been developing collaborative systems of care since 1989. The original initiatives, Integrated Services Projects (ISPs), focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities. ISPs receive \$80,000 annually in Mental Health Block Grant (MHBG) Funds.

Beginning in 2002, the collaborative process utilized by ISP was expanded with the development of Coordinated Services Team (CST) Initiatives. While CST uses the same wraparound process as ISP, the target group is broader and includes families and children who do not necessarily have an SED diagnosis but who do have complex needs. Funding for CST sites ranges from approximately \$33,000 to \$63,000 annually.

#### **Coordinated Services Team (CST) Initiative Expansion**

The expansion of children's mental health services has been a long-standing goal of the Wisconsin Council on Mental Health (WCMH), parents, providers, advocates, and the Department. Through increased funding from the Mental Health Block Grant, the CST initiative began in December 2002 with collaboration between multiple systems: mental health, child welfare, substance abuse, juvenile justice, and public instruction. Initiative funding is made available through a blend of Mental Health Block Grant and Substance Abuse Block Grant funds, state general purpose revenue, and child welfare dollars. This funding is being used to bring about a change in the way that supports and services are delivered to families who require substance abuse, mental health, and/or child welfare services. In addition to blended funding, the initiative reduces out-of-home placements, treats the family as a unit, develops strong cross-system partnerships, and supports family participation in the decision-making process.

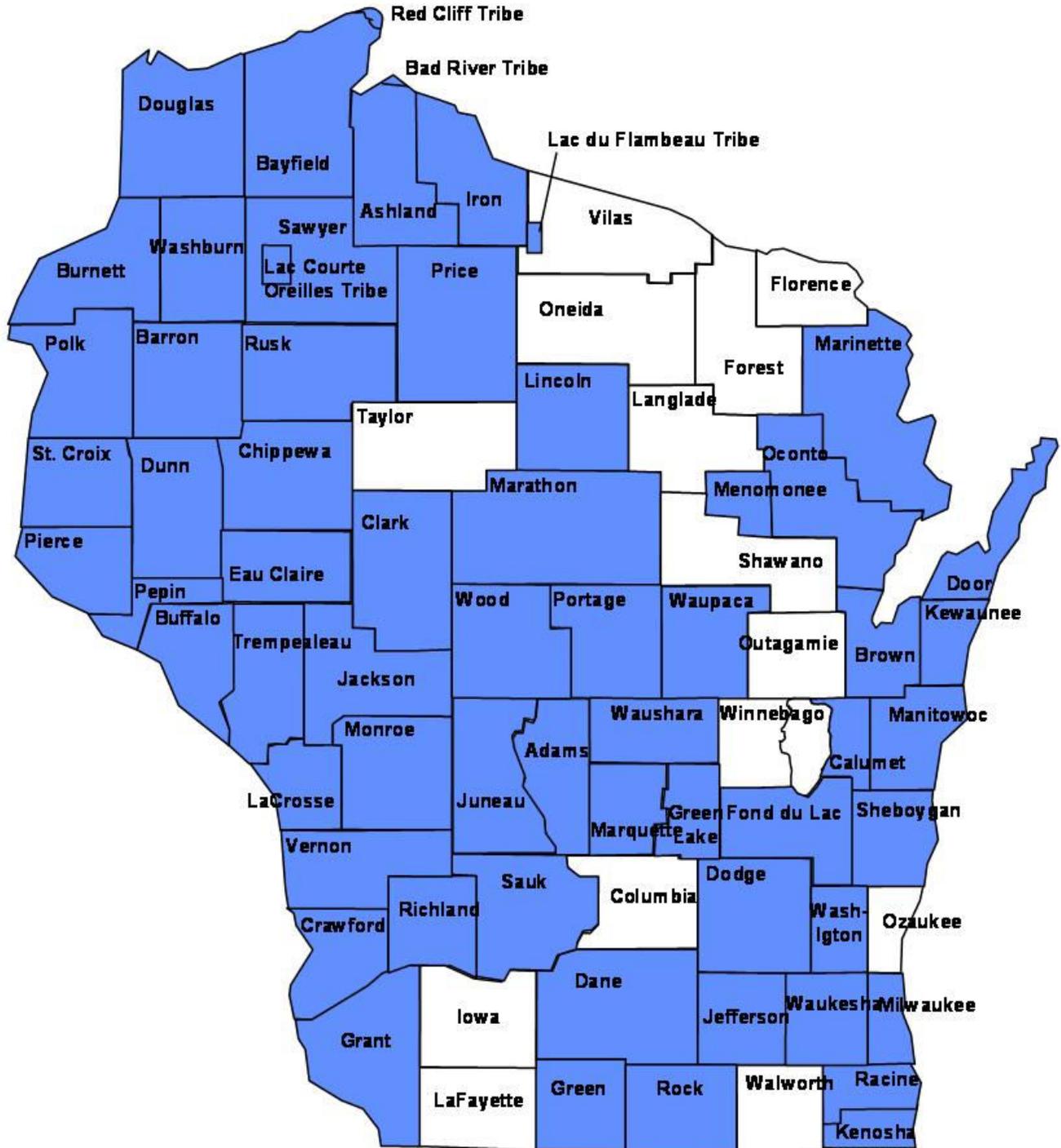
The CST approach provides an opportunity for parents, families, and consumers to be active members on state and local committees which establish policies and procedures and monitor progress, as well as to actively participate on individual family teams. Support is provided to ensure that barriers encountered by parents, families, and consumers are overcome. These barriers include timing of meetings, childcare, transportation, and training, and they are consistently resolved to ensure meaningful and successful involvement.

Parents, families, and consumers have been an active force fostering significant growth toward system change. The CST Executive Committee was formed in FFY 2005 to provide oversight and decision-making to the program. Membership includes division administrators and multiple system partners from mental health, substance abuse, and child welfare. Three additional CST committees have been formed to address training and technical assistance, evaluation, and funding.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2007, Wisconsin added six counties and two tribes to its CST initiative: Juneau, Ashland, Burnett, Menominee, Monroe and Price Counties; Lac Courte Oreilles and Red Cliff Tribes. In FFY 2008, four counties were added including: Vernon, Buffalo, Sawyer, and Wood. In 2009, two tribes and four counties were added: Bad River and Lac du Flambeau Tribes; Clark, Green, Kewaunee, and Oconto Counties. There are currently 37 counties and four tribes developing and/or sustaining CST initiatives. Additionally, Grant County has been developing CST without a full implementation grant, but they do receive some limited training and technical assistance funding. (Below are the counties that had CST and Integrated Services Programs as of July 2009.)

# Collaborative Systems of Care Serving Children and Families

Updated 7/1/09



### ***CST/ISP Activities During 2008***

As part of a MHBG Training/Consultation Fund administered through Wisconsin Council on Children and Families (WCCF), training and technical assistance was provided to CSTs and Integrated Services Projects (ISP). Statewide Project Director's biannual meetings were held in 2008. Over 60 people attended each meeting, including staff from all CSTs and ISPs, several private agencies, parents and others.

Several site-specific and regional trainings in the areas of systems change, coordinating committee development, team building, and service coordination were conducted during the budget year. Audience sizes ranged from a few to more than 50 participants, and consisted of individuals representing consumers as well as a variety of community agencies.

Training opportunities included but were not limited to:

- Maintaining Fidelity in Wraparound.
- Overview of the Coordinated Serves Team (CST) Initiative
- Combining the Lac Courte Oreilles Family Services Program and CST
- Overview of the CST Team Process and Team Membership
- Working with Children and Families in the Child Welfare System
- Presentation on Children's Long Term Support Waiver
- CST and Comprehensive Community Services
- Coordinating Committee Development
- Service Coordination and Team Process Training
- Building Services for Children in the Mental Health System
- Crisis Response Planning and CST
- CST Overview Presentations to Community, School, Child Welfare, and Mental Health Staff
- Working with Hospitals and Residential Care Centers
- CANS Assessment Tool

### ***Process to Receive Services within an ISP or CST***

Children and families can enter a wraparound program in several ways. In Milwaukee, the court refers most of the youth who receive services. Court referrals are accepted in some of the other counties as well. Other referral sources include schools, child protective services, law enforcement, mental health, substance abuse providers, parents, and hospitals or other inpatient settings. Each program determines its own referral and screening processes. However, all programs require parent participation with the team and treatment process. Upon enrollment, a child/family team is formed, consisting of both service providers and informal/natural supports of the family. This team then completes an initial assessment summary of strengths and needs and designs an individualized, family-centered, strength-based plan of care.

Each project has a screening and review process designed to evaluate the appropriateness of referral, using guidelines developed by its coordinating committee. The service coordinators continue the process by facilitating the organization of a child and family team made up of family members, other natural supports (friends, clergy, etc.), mental health and other professionals such as teachers, social workers, and/or substance abuse counselors, and advocates. The assembled team then creates a plan of care utilizing an array of services. New services may be added to the care plan as needed to meet new needs. Any change in the plan requires team approval. A family's needs may be outside traditional mental health

services. For example, if a pressing need of the family is to secure housing, then a housing search becomes the focus of the team's and the service coordinators efforts. Flexible funding may be used to complete the plan. There is growing recognition that alleviating family stress is critical to achieving positive outcomes.

### ***The Eight Key Components Evaluation Tool***

An evaluation tool used by wraparound programs and Bureau of Prevention Treatment and Recovery (BPTR) staff is the Eight Key Components assessment. The instrument includes eight sections of performance indicators with a rating scale. These eight sections include parent involvement, the structure and participation of the interagency group (coordinating committee), the family team's role with plans of care, funding, advocacy, training, goal monitoring and measurement, and transition for adolescents to adult living.

Program staff, directors, and sometimes coordinating committees complete the Eight Key Components assessment tool and are required by contract to identify components to improve and submit a brief plan of action for doing so. The completed component tool, in addition to being for self-review, helps structure site visits and feedback by BPTR staff.

### ***Wraparound Program Population Profile and Outcome Measures***

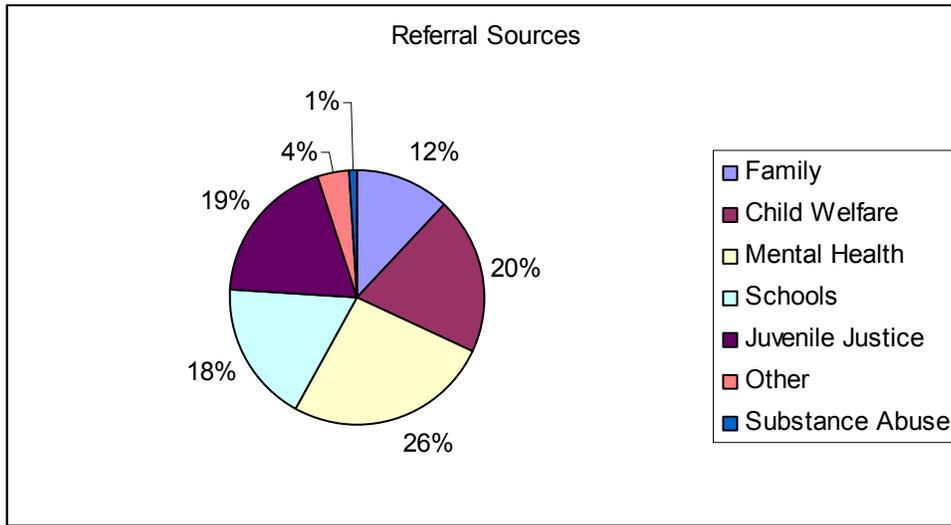
In FFY 2007, in an effort to improve data quality and increase data submission security, the development of a new data collection system began for ISPs and CSTs. The effort to improve the data system for these children's mental health programs was funded by Wisconsin's Mental Health Data Infrastructure Grant (DIG). The ISP/CST data system includes requirements to collect child demographics, enrollment and disenrollment dates, and diagnoses. In addition, data describing children's living situations, school academic performance and behavior, and juvenile justice system involvement are recorded in the data system every six months to monitor the child's progress and measure outcomes. The previous data system was installed on local providers' individual personal computers which made them responsible to work with their information technology staff to manage the data system and extract the data for submission to the BPTR. The new data system removes these responsibilities from local providers because it is a web-based system that is based on State servers. Data is recorded directly into the web-based screens and submitted to the State automatically upon entry without any extra steps. The web-based system also provides reports for local providers that they can use for quality improvement efforts. Staff from over 40 ISP/CST programs were trained on the use of the new system from May through July 2008.

### **2008 Integrated Services Projects (ISP) and Coordinated Services Teams Evaluation Results**

***The following data is from ISPs and CSTs submitted quarterly during 2008:***

- In 2008, there were 1,026 family teams served by ISP and CST sites across Wisconsin.
- The average length of enrollment per child and family team was 14.5 months.
- The average number of child and family teams enrolled per county was 27.
- The total number of children and family members served in 2008 was 3,523 (1,026 children and 2,497 additional family members).
- Sources of referrals made to Collaborative Systems of Care in 2008 are included in Table 1 below:

**Table 1**



***Comments on the impact of Collaborative Systems of Care on the larger service system:***

- There has been increased collaboration within our Department of Health and Human Services including the development of a multi-systems workgroup to improve services to children involved in multiple systems of care. In addition, staff completed trainings on Chapter 51 commitments and crisis intervention. Families have taken a more active role such as assisting in the development of crisis intervention training for parents.
- Families report utilizing the Family Center, YMCA, and the Boys and Girls Club. Given this participation in the community, there are less referrals to police, human services, juvenile justice, child welfare, and fewer hospitalizations.
- The CST project has started a systems change effort not only for our agency, but for the community as well. Our agency is now using the CST model with adult mental health consumers and the agency is presently submitting the application to begin a certified CCS (psychosocial rehabilitation) program. Many of these shifts have taken place because of the impact that the CST process has had in our system.
- The CST process has improved communication with community partners such as schools, medical providers, public health, law enforcement, Head Start, mental health providers, etc. We have also found that children who have a family team spend less time in alternate care and on a CHIPS order. Our placements have decreased significantly.
- Providing needed services to families as identified in the plan of care such as respite care, mentoring, and in-home family therapy is substantially less expensive than out-of-home placement costs. In 2008, if children had been placed out-of-home, the average cost for foster care and treatment foster care would have been \$35,000/month or \$420,000/year.
- Our CST program was able to receive reimbursement for Targeted Case Management. There are other savings due to prevention efforts which have reduced youth's involvement in the juvenile justice and child welfare systems. Interventions have reduced the number of out-of-home placements and reduced the number of days in out-of-home care. We have been able to build some natural supports to provide support and respite for families as one of the approaches to avoid out-of-home placement.

- Our agency has a relatively low out-of-home placement rate. Due in part to the use of the CST process with families, a number of children have returned home from a hospital or residential placement sooner than usual. Our CST project has consistently maintained 85 percent or more of our youth at home which has provided cost savings.

### ***ISP and CST Family Satisfaction Data for 2008***

Wisconsin Family Ties administered an annual Family Satisfaction Survey for ISP/CST families. The return rate for the 2008 survey was 44.0 percent, with 222 surveys returned out of the 504 surveys sent out. A five-point LIKERT scale was utilized: 1-Strongly Disagree; 2-Disagree; 3-Undecided; 4-Agree; and 5-Strongly Agree. (There were also two additional categories for questions that were "not applicable" and where there was "no response.") The results of the survey were generally very positive. The following questions received the corresponding scores:

1. I feel that I am treated as an important member of my child and family Team. 4.5
2. I am satisfied with the goals the Team and I have set. 4.3
3. The Team takes time to listen to my concerns. 4.4
4. My family is getting better at coping with life and its daily challenges. 3.9
5. I would refer another family/child to the Integrated Services Project. 4.2
6. My care coordinator speaks up for my child and family. 4.4
7. The Team is sensitive to my cultural/ethnic/religious preferences and values. 4.3
8. The Team schedules services and meetings at times that are convenient for my family and me. 4.5
9. If my child is 14 or older, the Team has a plan to acquire the services he/she will likely need when 18. 3.6
10. I feel the Team understands my child's strengths in setting goals and making plans. 4.3
11. I Know the Team uses my child's strengths in setting goals and making plans. 4.3
12. Overall, I am satisfied with the efforts of the Team on my family's behalf. 4.3

### ***Child and Adolescent Needs and Strengths (CANS) Update***

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 dimensions and items used in the CANS were developed by focus groups with a variety of participants including families, family advocates, representatives of the provider community, mental health case workers and staff. The CANS measure is seen predominantly as a communication strategy. The CANS is designed for use at two levels: for the individual child and family; and for the system of care. The CANS provides a structured assessment of children along with a set of dimensions relevant to planning and decision-making. Also, the CANS provides information regarding the child and family's needs for use during system planning and/or quality assurance monitoring.

The CANS instrument for children with mental health needs includes domains that cover Clinical Problem Presentation, 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.

### ***Background of the CANS in Wisconsin***

Prior to utilizing the CANS instrument in Wisconsin, the Child and Adolescent Function Assessment Scale (CAFAS) was used as a 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 an alternative assessment tool. Over the course of several months, and with input from people across the state, several alternative tools were researched and reviewed. In the fall of 2007, the Child & Adolescent Needs & Strengths - Mental Health (CANS-MH) was chosen as a tool to pilot. With the help of the tool's primary developer, John S. Lyons, Ph.D, 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.

### ***Current Highlights***

There are currently 47 individuals representing 35 sites as well as four staff from White Pine Consulting Services who are "Certified CANS Trainers." These individuals were trained by John S. 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 41 individuals across the state who have subsequently been trained by the CANS Trainers and received certification as "Certified CANS Raters." A statewide list of certified CANS trainers and raters is available upon request. There are currently three sites that do not have certified trainers or raters. A CANS training was held in early 2009.

In early 2008, shortly after the initial "Training of Trainers," a subcommittee of CST/ISP project staff, State staff, and White Pine Service, Inc. consulting staff compared the "CST/ISP Assessment Summary of Strengths and Needs" and the CANS tool with the goal of integrating the two tools into one. Over the coming months, drafts were piloted. Two conference calls were held to solicit feedback and suggestions from sites. A working draft of the combined tool is now available and being used by several sites across the State.

In October 2008, individuals from sites that attended one of the two Training of Trainer sessions facilitated by John S. Lyons, Ph.D, were asked to complete a short questionnaire. The purpose of the questionnaire was to capture sites' experiences in utilizing the CANS - both their experience in training others, as well as the utilization of the tool with families and teams. Twelve sites participated (Dunn, Chippewa, Portage, Price, Ashland, Adams, Polk, Washburn, Pierce, Sauk, Dodge, and Waupaca Counties). In general, responses were positive. The suggestions/issues raised are reflected in the expected outcomes of the CANS Work Plan for 2009.

A "CANS" page on the [www.wicollaborative.org](http://www.wicollaborative.org) website 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.

### ***Comprehensive Community Services Benefit (CCS)***

The 2003-05 state budget included authorization to expand the scope of psychosocial rehabilitation services offered in Wisconsin under the Medical Assistance (MA) program. These services are known as Comprehensive Community Services (CCS). The rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to both children and adults, including older adults, whose psychosocial needs require more than outpatient therapy. Certified programs are required to serve consumers across the life span that fit the eligibility criteria for CCS. Certified CCS programs are funded by Medicaid with counties providing the non-federal share. These programs may also coordinate with other existing funding sources and other agencies that are involved with consumers.

Starting in 2006, the DMHSAS has provided start-up funds for counties to establish new CCS programs. The DMHSAS used State General Purpose Revenue (GPR) funding originally intended as start-up funds for adult Community Support Programs (CSP), as described previously. In 2005, the DMHSAS successfully obtained a change in the requirements for this funding to allow its use to be expanded to CCS programs. Some examples of service delivery development in which counties can engage include: local systems change to provide for comprehensive access; development of a fluid continuum of care; revision of assessment and care plan processes and forms to assure they are recovery based; staff training in outcomes, trauma informed treatment and recovery based treatment; and how outcomes for consumers and general quality service delivery will be measured at the local level. In addition, a CCS coordinating committee must be developed which includes 51 percent consumer membership.

#### Certified CCS Programs

As of December 2009, 29 counties have received certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

#### ***CCS and CSP Start Up Grants***

The purpose of the Start Up grants is to create a change in the way mental health services are provided in specific counties. The final outcome could be either a new Community Support Program (CSP) or a new Comprehensive Community Services (CCS) program. In 2008, there were no applications for starting Community Support Programs. Seven grants of \$40,000 each were provided for the development of CCS programs.

These grants require the completion of 22 outcomes that focus on system change. For example, counties must develop and train an advisory committee made up primarily of stakeholders with a minimum of one-third consumers to assist in the development of the CCS program. Counties must develop training programs to ensure that staff have the skills for person-centered, recovery-oriented service provision; and counties must develop policies and procedures to implement person-centered and recovery-oriented practices. Progress toward the ultimate outcome of developing an application is measured by progress toward the 22 system change outcomes. Four counties were awarded 2009 start up funding to develop a CCS program including: Columbia, Iron, Monroe, and Walworth. (See CCS map below.)



## II. Family/Consumer/Peer Support

### *Wisconsin Family Ties (WFT)*

Wisconsin places a high value on increasing the meaningful involvement of parents and caregivers in the treatment of their children. The DMHSAS believes the system of care should be family driven. To increase the likelihood of positive outcomes in the lives of families, mental health block grant funds are contracted to Wisconsin Family Ties (WFT). WFT provides peer support, education and advocacy in various regions of the state by employing “Family Advocates” and conducting regional educational opportunities for parents and professionals. In addition, there are several counties that fund family advocate positions through WFT. This family-to-family support is crucial for systems transformation.

WFT is a statewide organization run by families for families with children and adolescents who have emotional, behavioral and mental disorders. Their mission is to bring hope to families and their children. WFT accomplishes this by providing a variety of parent-to-parent support, education, and advocacy services, as well as information on family rights, available public/private programs, and treatment options. WFT produces a quarterly newsletter, has a website, and offers a toll-free help line for information. The organization also provides resource materials, assists in the formation and maintenance of community-based support groups, provides social and recreational opportunities, and sponsors educational opportunities through scholarships to family members. WFT fights stigma and raises awareness about children with mental health needs. It helps families become empowered, so they can help not only themselves, but others in similar situations.

### *2008 WFT Activities*

In 2008, Wisconsin Family Ties launched a major child & adolescent mental health awareness campaign, called *Is Anyone Listening?* They commissioned the Figureheads, an award-winning hip hop group, to write five songs related to issues of children’s mental health. A CD was released in April, along with a website ([www.IsAnyoneListening.org](http://www.IsAnyoneListening.org)) that features a music video of one of the songs. These products were utilized to promote Children’s Mental Health Awareness Week in May, 2009.

Wisconsin Family Ties took over coordination of the annual Children Come First Conference in 2008. Approximately 300 adults and 80 children attended the 2008 conference. Keynote speakers were Pete Feigal, a nationally-known speaker who has battled depression for over 35 years, and Dr. Antoinette Kavanaugh, co-director of the Cook County (Illinois) Juvenile Court Clinic. Evaluation results showed that the conference was effective in raising awareness of key children’s mental health issues and that participants learned information that will help them perform their job or parenting responsibilities.

During the year, Wisconsin Family Ties developed several workshops and training curricula. Two important additions to our training catalog are *In Our Shoes*, a one-hour presentation designed to help people understand the challenges faced by families raising a child with mental health issues, and *Guiding the Way Toward Family-driven Care*, a half-day workshop to help service organizations orient their practices toward the principle of family-driven care.

Wisconsin Family Ties continued to provide leadership on issues relating to the use of restraint and seclusion. WFT formed a coalition along with Disability Rights Wisconsin and Wisconsin FACETS to research and recommend restraint and seclusion policy changes for both schools and treatment facilities. The coalition issued a report in spring of 2009.

### ***Additional Family Advocacy***

Additional family advocacy, parent education, and support are provided by the National Alliance on Mental Illness of Wisconsin (NAMI). Wraparound Milwaukee also has a strong family support and advocacy network called Families United of Milwaukee, Inc. operates in the Milwaukee Metro area in providing essential peer-to-peer support to families who have children with SED and are enrolled in Wraparound Milwaukee. The group serves families throughout Milwaukee County, including families that are not enrolled in Wraparound Milwaukee. In addition, Wisconsin is fortunate to have a federally funded group to assist parents primarily with special education issues called the Wisconsin Family Assistance Center for Education, Training and Support. Finally, the Mental Health Association of Milwaukee County provides a myriad of support, advocacy and educational opportunities for families.

### ***National Alliance for the Mentally Ill (NAMI) Wisconsin***

NAMI Wisconsin expanded two of its signature programs, *Family-to-Family* and *In Our Own Voice* for focus in 2008. Two new state trainers offered a second *Family-to-Family* teacher training during fall to augment the August training given by veteran state trainers. The *Family-to-Family* course is taught in 20 sessions offered by local affiliates by a cadre of over 75 teachers.

The NAMI Wisconsin Consumer Council (NWCC) was formed in 2005. The NWCC is a standing committee of the NAMI Wisconsin Board of Directors and derives its organizational structure from the NAMI National Consumer Council. The NWCC holds consumer leadership summits and has an active, productive and influential membership. The NAMI Wisconsin Recovery Project maintains its own website and publishes the Recovery Newsletter, which is included in the *Iris*, NAMI Wisconsin's quarterly newsletter. Three issues of the Recovery Newsletter were published and disseminated during 2008. Each issue of the Recovery Newsletter was distributed as an insert to the *Iris*. Approximately 6,000 copies of each issue of the Recovery Newsletter were distributed for a total of 18,000 issues. In addition to sending the Newsletter to individuals, additional copies were disseminated to Wisconsin Libraries and other relevant agencies. During 2008, the NAMI Wisconsin Consumer Council contributed articles to the Recovery Newsletter as well as other Wisconsin consumers. A total of 12 stipends were given to consumer reporters for articles that they wrote that were included in the Recovery Newsletter.

Two Consumer Leadership Summits were held during 2008. The first was held on April 24, 2008 in Racine, Wisconsin. It was coordinated with the NAMI Wisconsin Annual Conference which was held on April 25 and 26, 2008. A featured speaker at the summit was Lizzie Simon, author of "Detour: My Bipolar Road Trip in 4D". The summit was attended by 68 consumers.

### ***Disability Rights Wisconsin (DRW)***

Wisconsin's protection and advocacy agency is Disability Rights Wisconsin (DRW), which receives funding directly from the federal Center for Mental Health Services and from the MHBG. The DRW is mandated to protect and advocate for the rights of individuals with mental illness and their families, and to investigate reports of abuse and neglect in facilities or community programs that provide care or treatment for 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. 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 mental illness, stigma, recovery, recovery-oriented services, trauma informed services, and access to appropriate services.

In 2008, DRW focused its goals and resources on furthering the concepts of consumer empowerment, recovery and stigma reduction, on protecting and enhancing consumer rights, including access to services, in community treatment and support programs, and on addressing issues related to trauma and to persons with mental illness who are in the criminal justice system. In 2008, DRW received an increase of \$10,000 in MHBG funds for a total of \$75,000 for the federal fiscal year. DRW added additional activities with the increase in funds including:

- Providing direct advocacy assistance for an increased number of consumers who are experiencing rights violations in community treatment programs and difficulty in accessing community services (including persons on probation/parole).; and
- Providing one or more additional Guided Reflections trainings on Implementation on Recovery Concepts.

### ***DRW 2008 Activities***

1. Patient rights protection in community treatment programs and reduction of stigma due to discrimination were supported by providing peer and self advocacy training and individual advocacy assistance.
2. The booklet: "Where to Now? A field guide to resolving complaints within the mental health system" was reprinted.
3. Direct advocacy assistance to consumers who were experiencing rights violations in community treatment programs and difficulty in accessing community services (including persons on probation/parole) was provided.
4. Work with the Bureau of Prevention Treatment and Recovery (BPTR), the Recovery Implementation Risk Force, and the peer support committee was continued. Training on recovery concepts was provided as requested.
5. DWR worked with BPTR to provide input into the revision of the outpatient rules. DWR advocated for the inclusion of recovery concepts, such as consumer collaboration and informed consent into the rules.
6. DRW provided staff to operate the Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health. The committee focused on improving mental health services in county jails and on reintegration of offenders, with a special emphasis on collaboration between community mental health and substance abuse services and corrections programs.
7. DRW worked with BPTR, consumers, mental health, substance abuse, sexual assault and domestic violence service providers and others on improving services for persons who have mental health problems and a history of trauma. This included participation with the New Partnerships for Women Project, as well as making presentations on the relationships between mental health, substance abuse, and trauma. DRW worked with the Department of Health Services and DMHSAS to develop plans and strategies across the Department for improving services to this population.
8. DRW took an active role in promoting consumer and family involvement and activities to eliminate discrimination and stigma against persons with mental illness. They participated in Wisconsin United for Mental Health and coordinated activities with the Milwaukee Task Force on Mental Health.
9. DRW collaborated closely with existing consumer organizations including: Grassroots Empowerment Project, Inc. (GEP), National Alliance on Mental Illness-Wisconsin (NAMI), Mental Health America of Wisconsin (MHA), Wisconsin Family Ties (WFT), and the Mental Health Council to develop coordinated positions and to strengthen the consumer and family movements in Wisconsin. This included participation on the Council's Legislative and Policy Committee.

### **III. Systems Change and Transformation**

#### **Prevention and Early Intervention**

Prevention and early intervention efforts are an important part of Wisconsin's continuum of care. The Mental Health Association (MHA) initiatives address the need to intervene early in the children's lives; particularly those children who are at risk of developing a serious emotional disturbance.

#### ***Mental Health America of Wisconsin***

Mental Health America (MHA) in Wisconsin is the lead contracted agency for MHBG-funded prevention and early intervention activities. MHA works with local school districts on suicide prevention projects. Technical assistance is provided to the projects by providing direct guidance and resources from experts in the area of child suicide prevention such as the UCLA Center for Mental Health in Schools. MHA offers educational opportunities to school districts, mental health providers, and parents regarding youth suicide and school mental health through conference presentations and publications. Another goal of MHA is increased screening for depression and other mental health disorders in primary care settings. MHA provides information on its website for primary care physicians regarding the integration of mental and physical health and the importance of screening. The website provides information on how to screen, diagnose and treat persons with mental health disorders within a primary care setting. Additionally, the agency has a plan to bring medical administrators, health plan providers, consumers and healthcare providers from across the state together to promote best practices in comprehensive health service delivery. MHA continues to identify potential strategies and barriers to the implementation of best practices by stakeholders and will engage key partners in planning future steps in the process. MHA is also the recipient of one of the federal Garrett Lee Smith Suicide Prevention Grants, which expands their suicide prevention efforts in the state.

#### ***MHA Activities and Deliverables in 2008***

In 2008, MHA was involved in a number of initiatives across the state including:

- Implementing the Garrett Smith Youth Suicide Prevention Grant;
- Initiating the integration of primary care with mental health and substance abuse treatment;
- Working with Wisconsin United for Mental Health;
- Working with the Wisconsin Prevention Network;
- Involving the Child Welfare system with mental health initiatives; and
- Providing resources for child protective services and mental health workers as well as web-based resources for the state.

#### ***Garrett Smith Youth Suicide Prevention Grant***

MHA continues to implement all aspects of this grant. Some of the activities of the initiative include all-site tele-conferences and project site visits; all-site meetings (topics included sustainability of projects and review of evaluation instruments); training on "Assessing and Managing Suicide Risk"; attending Garrett Smith grantee meetings, training and consultation to non-project sites, trainings for community stakeholders; and dissemination of project information to the community and co-chairing the Suicide Prevention Initiative. All sites have updated work plans. Projects supported by funding through SAMSHA included evaluation of the Well Aware newsletter, development of a social marketing campaign, development of mini-grants, and development of a Burden of Suicide report by the Medical College of Wisconsin (MCW) and the Division of Public Health.

Cross-site and local evaluation of project sites is being implemented including:

- Training Exit Surveys completed for all training events,
- Product and Services Inventory completed quarterly,
- Second round of Community Infrastructure Surveys completed,
- Early identification, referral and follow-up surveys completed, and
- Training Utilization and Penetration Survey completed.

Additional Statewide Efforts:

- Disseminated project CDs and other resources.
- Expanded involvement with tribes through the State-Tribal Collaborative for Positive Change, the Bemidji Region of the Indian Health Services suicide prevention conference and a youth suicide prevention conference sponsored by the Oneida Tribe.
- Provided training and consultation to a number of non-project sites, including Dane County, Vernon County, Kenosha County, Altoona and Eau Claire Schools.
- Evaluated Well Aware newsletter and planning for next steps in informational communications to schools.
- MHA staff continues to co-chair the Suicide Prevention Initiative and disseminate SPI e-news.
- Began work on statewide strategic planning summit to be held in April 2009.

Additional special projects included:

- Three regional meetings--Conducted a southeast regional training on Assessing and Managing Suicide Risk (AMSR) for 45 clinicians; a northern regional training which provided suicide prevention education and action planning and AMSR training for 55 clinicians; as well as a Chippewa Valley regional training attended by 400 people which included presentations by the Department of Public Instruction and Clinicians.
- Completed scripting for American Sign Language of SOS video. Production planning in process.
- Initiated social marketing project with Entercom Communications in southeast Wisconsin, in conjunction with Charles E. Kubly Foundation:
  - Web ads, cumulative impressions=916,312 (through mid-October 2008); click through rates were 2-3 times national average; 1124 total click throughs.
  - Streaming ads; 6,449 spots with 237,042 impressions.
  - Public affairs shows.
  - WSSP (sports radio) Interview
  - Podcasts in production.
  - All materials created for on-air, on-line use can be found at: <http://wmyx.radiotown.com/mhawrecap/recap.html>
- 6 Mini-grants awarded through competitive application process:
  - Stockbridge-Munsee Tribe; QPR training and Native American Lifeskills implementation in schools.
  - Dane County Safe Communities Coalitions; initial QPR training-of-trainer held in May 2008, second training scheduled for October 2008.
  - School District of Janesville; QPR and AMSR trainings.
  - Opportunities Inc./Delinquency Prevention Council of Jefferson Co.; summit held Oct. 8<sup>th</sup> 2008, about 60 people attended for suicide prevention education and QPR training.
  - School District of Antigo; working on revision of school policies and trainings.

- Wisconsin Assn. of Runaway Services; Training completed for about 30 workers on QPR and mental health issues in youth on Sept. 30, 2008; ongoing work with agencies to implement policies.

#### *Burden of Suicide in Wisconsin*

This report was released in September of 2008, during Suicide Prevention Awareness Week. (The link for the report is: <http://www.mhawisconsin.org/Uploads/prevention/bosfinal/9.5.pdf>) It contains detailed data on suicide and suicide attempts by age, gender and other circumstances. County level reports are being produced on a regular basis until all are completed.

#### *Wisconsin United for Mental Health (WUMH)*

MHA maintains an active role on the WUMH steering committee. Staff participated in the development of a successful grant application for the National Anti-Stigma Campaign. MHA staff is involved in the Lt. Governor Barbara Lawton's Implementation Coalition for her Task Force on Women and Depression and the Mental Health Day of Action. Additionally, MHA staff worked on a presentation to the State Division of Public Health on progress on the mental health goals for Healthy Wisconsin 2010.

#### *Wisconsin Prevention Network*

MHA staff continues to be involved on the Board of the Wisconsin Prevention Network. MHA staff is involved in the State Council on Alcohol and Other Drug Abuse's Prevention Committee and its Underage Drinking subcommittee. In this capacity, they are seeking to promote the understanding of the relationship between youth substance abuse, mental health issues and suicide.

#### *Child Welfare*

MHA continues to expand both its Invisible Children's Program (ICP) and its new Family Center (through funding from the Children's Trust Fund). Both of these efforts intersect considerably with the child welfare system in Milwaukee. As a result of these initiatives, the MHA continues to enhance its expertise and stature with regard to the mental health needs of children and adults in the child welfare system. In 2008, the MHA joined the Milwaukee Child Welfare Partnership for Professional Development's Foster and Adoptive Parent Training Advisory Committee.

The MHA is expanding mental health child welfare training to South Eastern region that includes Dane County. It provided three trainings in 2008. MHA is also partnering with the Children's Service Society of Wisconsin to develop and support ICP-like services in Marathon and Rock counties. It submitted and received a Child Abuse and Neglect Prevention Grant for the project. MHA will provide training, consultation, resources, and site support. MHA also provided training on Empowering Families of Milwaukee and the Home Visitors program.

#### *Resources*

MHA is developed a parenting tool kit for case workers in child welfare and mental health. The tool kit includes recovery and crisis work plans for parents and their children and 12 parenting supplements related to parental mental illness. Supplements enhance regular parenting curricula such as the Nurturing Program. Tool kits can be used individually by case workers or in group settings. Tool kits are available on-line. The MHA also supports a web site which is available to all 72 counties which is being expanded as new information is available. Approximately 5,000 individuals access the county information monthly.

#### ***Infant and Early Childhood Mental Health***

Governor Jim Doyle adopted the plan developed by the Wisconsin Alliance for Infant Mental Health (WI-AIMH), as a component of his KidsFirst Initiative. The plan weaves infant and early childhood social

and emotional development principles into the fabric of all systems that touch the life of children under the age of five and encompasses mental health promotion, prevention, early intervention, and treatment.

The vision of WI-AIMH 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 has created an internal Infant and Early Childhood Mental Health Leadership Team 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.

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.

### **Accomplishments and Goals**

Accomplishments in 2008 include:

- Provision of state wide training on DC: 0-3R
- Development and distribution of educational materials for caregivers
- Provision of technical assistance regarding development of community infant mental health plan to early childhood community groups
- Held first state-wide infant and early childhood mental health conference

DHS members are also active participants on the WI-AIMH Advisory Council, the Wisconsin Brain Team, and wraparound programs that serve young children with mental health issues.

### ***Child Welfare Screening Pilots***

In August of 2007, the Division of Mental Health and Substance Abuse Services, in conjunction with the Division of Children and Family Services, awarded seed money to 10 counties to test the process of screening for mental health and substance abuse issues for children coming into the child protective services (CPS) system. Those counties were: Bayfield, Brown, Columbia, Grant, Jackson, Marquette, Menominee, Outagamie, Sawyer, and Sheboygan. Pilot counties were required to formulate a memorandum of understanding (MOU) with providers, their mental health and substance abuse units within their system, and other interested parties to ensure referral for mental health and substance abuse assessments took place for those children scoring positive on the screening tool.

### ***Progress of Child Welfare Screening Pilots in 2008***

The Child Welfare Screen was developed to determine the extent that children coming into the Child Welfare System have been exposed to trauma, violence and abuse and whether they are experiencing mental health or substance abuse issues. The screen was initially developed in accordance with a Federal mandate for mental health and substance abuse screening. In response to the mandate, Child Welfare invited representatives from the mental health system in the state to collaborate on development and implementation of the screen. The screen is implemented during the initial investigation into the child's case and Child Welfare works with the child and family to obtain appropriate services for them based on needs reflected in the screen.

In 2007, the proportion of children testing positive (leading to a referral for assessment) on the screen appeared to be lower than expected for the ten sites, varying from seven percent to 39 percent. In

response to these results, focus groups with five of the 10 counties were conducted. Several issues emerged through the focus groups:

(1) The criteria for a positive score are possibly too narrow; (2) Child Protective Service workers need to be better trained to understand the impact of trauma; and (3) State staff need to do a better job of training on the tool. Suggestions for improvement on the screening process included incorporating the screen into the WISACWIS (the Child Welfare System database) and providing more comprehensive training on the tool and the types of issues the screen should address. Additionally, state staff have recommended that in the future, agencies implementing the screen provide lists of service providers, including the types of insurance they accept, for parents who receive referrals to services.

During late 2008 and 2009, representatives from Child Welfare and the state public mental health system worked on a report which outlines the next steps in implementing the screen statewide. The new 2010 pilot will target five counties in the northeast region of the state. Training will be updated to better address the impact of trauma.

## **IV. Training**

### ***The Crisis Intervention Network***

The Crisis Intervention Network, numbering over 200 individuals representing all 72 counties, is a group of state agency staff including DMHSAS staff, advocates, consumers, family members, and county providers. The Crisis Network remains actively involved in the promotion of certification for county crisis programs by offering technical assistance to develop county crisis programs, data collection regarding crisis care, measures of its effectiveness and utilization, and in the coordination of the annual Crisis Intervention Conference. The Crisis Network and the Crisis Conference both work to promote the enhancement of crisis intervention services in the community. The network has developed a Best Practice model for better coordination between law enforcement and crisis services at the point of determining if an individual should be held in emergency detention and best disposition. Regional training sessions tailored to meet local needs have been and will be offered to promote this Best Practice model.

The Network continues to meet quarterly. Information is exchanged regarding crisis intervention issues, i.e., stabilization, crisis beds, mobile crisis response, and suicide awareness and prevention strategies. Other information shared is in regard to suicide screening and risk for suicide, contracts and agreements, collaboration between agencies, and insurance and Medicaid billing issues.

### ***Regional Crisis Response System***

In response to the 2004 Request for Proposal for multi-county regional crisis intervention/stabilization program expansion, eight applications were received, of which, six were funded at \$100,000/year for up to five years. The purpose of these funds is to develop or expand crisis services using a multi-county/tribal agency approach. Due to the fact that many smaller counties do not have the resources for their own certified crisis stabilization program, the funds have been targeted for regional or multi-county projects so that counties can collaborate to meet their needs.

The funds are being utilized to develop and/or enhance crisis services in order to reduce hospital/institutional admissions. There is \$500,700 available per year of state GPR funds for this initiative. Funding for one additional Multi-County Crisis Program (Milwaukee/Waukesha) was made available in 2005. Local savings from reduced hospital/institutional placements along with the Medicaid reimbursements would help to sustain the programs. Of the 35 counties involved in the six Regional Multi-County Crisis Programs, only two are not certified HFS 34 Subchapter III.

## ***Crisis Intervention Conference***

The 12<sup>th</sup> Annual Crisis Intervention Conference was held in September 2008. It was well-attended by multiple system partners, such as law enforcement, county human services administrators and staff, CSP, education, health care providers, public and private mental health care providers, consumers, family members, and advocates. Attendance over the past three years has been 500 - 600 participants. Conference hours apply to required on-going training for individuals providing certified mental health crisis services under HFS 34. Other required crisis training opportunities include supervision, consultation, and backup are provided independently by each certified crisis program according to the standards set forth in HFS 34.

Topics presented in Keynote Addresses for the conference included:

- Is Forced Treatment an Oxymoron? Questions for Practice
- Kids in Crisis: Strategies for Unmasking Hidden Trauma Wounds
- Care and What Matters in the Recovery Process

Topics presented in the Breakout/Workshop Sessions for the conference included:

- Lessons Learned: Living With Serious Severe mental illness
- Teens Who Hurt: Effective Strategies for Working with Troubled Adolescents
- Crisis Intervention Collaboration with Law Enforcement and Mental Health
- Working with People that Don't Want to Work With Us
- Crisis Intervention with People with Personality Disorders
- Role of Peer Specialists and Their Value in Crisis Work
- The Psychiatric Emergency Assessment of the Geriatric Patient
- Crisis Work with Children and Adolescents After a Suicide Death
- Crisis Plans for Suicidal Youth
- Aging and Mental Health-We're All In This Together
- Rethinking the Risks for Violence
- Untangling Intangible Loss in Traumatized Children and Adolescents
- Working with People Who Cut
- Brain Injury Basics for Professionals
- Substance Use Disorders: Identification and Treatment in Adolescents
- Components of a Successful Peer Specialists Program
- Suicide Assessment Protocol-Trying to Satisfy Everyone
- Protective Factors: What Helps an Individual Stay Alive?
- Using Psychiatric Medicine in the Recovery Process: Helping Clients Work Through Decisional Uncertainty
- Crisis Assessment 101
- Psychiatric Advance Directives and Their Value in Crisis Work
- Community Based Diversion Options
- Valuing Recovery Principles In Inpatient and Community Settings
- Assessment of Imminent Risk for Suicidal Callers
- What You Can Do To Prevent Suicide in Youth
- PTSD & Readjustment Concerns of Returning OEF/OIF Veterans
- Cultural Competency

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	72,824	79,514	80,309	82,811	103.12
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** To increase the number of adults who have access to services in the public mental health system. (National Outcome Measure)
- Target:** Increase the number of adults served through the public mental health system in FFY 2009.
- Population:** Adults with SMI.
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Number of adults 18 and older receiving mental health services in FFY 2009.
- Measure:** Number of adults 18 and older receiving mental health services in FFY 2009.
- Sources of Information:** Human Services Reporting System (HSRS) data.
- Special Issues:** The data to monitor Wisconsin's progress on access to care for adults will be taken directly from Basic Data Table 2A, which Wisconsin is required to report in the annual Implementation Report.
- Significance:** Mental health services are expanding in Wisconsin, but increased access to a comprehensive public mental health system is still an important issue as demonstrated by the estimated prevalence rates for the state.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2009, there are 78 CSPs in Wisconsin which meet the standards for certification established by the DMHSAS. Wisconsin will continue to expand the use of CSPs by funding new counties for start-up and certification costs. The implementation of CSP is based on the ACT model. A CSP is a coordinated care and treatment program providing a range of treatment, rehabilitation, and support services in the community through an identified treatment program and staff ensuring ongoing therapeutic involvement and individualized treatment for persons with severe and persistent mental illnesses. Of the eight counties remaining without a CSP, seven are rural counties. In FFY 2009-2010, Wisconsin plans to provide \$100,000 in MHBG in start-up funds to any of those counties that are interested in building their capacity to become a certified CSP provider. Counties will be notified about the availability of the funds, and technical assistance made available to those counties.

In addition to CSP, the Comprehensive Community Services (CCS) benefit provides an expanded choice of MA-funded mental health services. Wisconsin continues to increase the number of certified CCS programs in the state on an annual basis by providing \$100,000 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four were added in FFY 2008. The CCS benefit serves both adults and children. Increasing the number of counties that provide CCS benefits will bring services to more adults in new areas of the state. Twenty-nine counties have certified CCS programs as of November 2009.

Implementing tele-health also provides a vehicle for expanded mental health services in rural parts of the state where these services are currently unavailable. Tele-health services expanded in FFY 2008 to three additional counties. In 2009, 15 new providers, including six new county providers and 26 new programs, including 15 county programs were certified. The Division of Mental Health and Substance Abuse (DMHSAS) has contracted with UW-Madison to bring its clinical resources to rural Wisconsin via audio and video communication technologies (tele-health). A three-pronged approach will be used: (a) a tele-health clinics will bring UW-Madison expertise to the counties with greatest need to provide direct clinical case consultation and treatment, (b) the quality of the existing workforce will be enhanced

through quarterly distance education initiatives focusing on evidence-based treatments, and (c) the Mental Health and Education Resource Center (MHERC) on the UW Madison campus will provide point-of-need high-quality information to mental health professionals and consumers through a "warm line" staffed by a highly trained and experienced medical/mental health librarian.

This project will build upon the existing structure within the UW-Madison and DHS. DHS will serve as an interface between the local 72 county mental health systems, ensuring that the counties most able to benefit from tele-mental health services are prioritized. In addition, DHS will assist in coordinating distance education programming and ensuring county-by-county access to MHERC services. Through its programs in psychology, psychiatry, and other mental health disciplines, UW-Madison will provide state-of-the-art education programming and clinical tele-health services. There will be significant participation by UW-Madison professional trainees (under supervision of UW faculty).

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	9.91	11.37	10	15.34	65.19
Numerator	876	1,073	--	1,377	--
Denominator	8,839	9,441	--	8,979	--

Table Descriptors:

**Goal:** Decrease the rate of readmission to psychiatric hospitals within 30 days. (National Outcome Measure)

**Target:** Decrease the rate of readmission to psychiatric hospitals within 30 days by approximately one percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of adults discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 30 days.

**Measure:** Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 30 days.  
Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** This is a national outcome measure required by CMHS. The data to monitor readmissions to psychiatric hospitals for adults will be taken directly from Uniform Reporting System (URS) Data Table 21, which states are required to report in the annual MHBG Implementation Report.

**Significance:** Community-based treatment is at the core of the Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of approximately one percent in the readmission rate over the FFY 2009 period. There are a number of programs that will likely have an impact on this indicator. Expanding services in three program areas over the next two years will reduce the rate of readmission to psychiatric hospitals by making more services more readily available in the community.

The availability of Community Support Programs (CSP) services will remain a primary strategy to reducing readmissions. In many cases, the next step going down the continuum of care for consumers from psychiatric hospitals is a CSP. Since CSPs are available in a majority of Wisconsin counties now, they will continue to play an important role in decreasing psychiatric hospital use.

In FFY 2009-2010, Wisconsin plans to offer \$100,000 in MHBG in start-up funds to any of those counties that are interested in building their capacity to become a certified CSP provider. Counties will be notified about the availability of the funds, and technical assistance made available to those counties.

Increasing the number of crisis programs through five multi-county initiatives also has served to reduce the number of inpatient placements, including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years.

Wisconsin continues to increase the number of certified CCS programs in the state on an

annual basis by providing \$186,900 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four were added in FFY 2008. The CCS benefit is for both adults and children. Increasing the number of counties that provide CCS benefits will bring services to more adults in new areas of the state. Twenty-nine counties have certified CCS programs as of November 2009.

When individuals are discharged from psychiatric hospitals, these are the expected increased service options that will be available to them. Becoming engaged with these service/program options after discharge from a psychiatric hospital should reduce the incidence of readmissions.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Target not achieved. The number and cost of care for the persistent and severely mentally ill continues to grow in Wisconsin. Residents of Wisconsin also have a higher rate of use of state psychiatric hospitals and community inpatient psychiatric services compared to the national average. At the same time, state and county budgets are shrinking due to reduced revenue. The Governor's Budget includes several measures aimed at reducing institutionalization and expanding community treatment for people with mental illness. As of January 2010, Wisconsin counties will be required to contribute to the cost of care for children and elderly patients at state psychiatric hospitals. This change will increase the fiscal responsibility of Wisconsin counties at a time when county administrators are cutting services or raising taxes to offset reduced revenues.

The aim of the Wisconsin Mental Health Collaborative is to reduce unnecessary/inappropriate admissions and readmissions to inpatient facilities among the state's persistent and severely mentally ill. Experts in quality improvement from the University of Wisconsin (NIATx) are partnering with the State Division of Mental Health and Substance Abuse Services to identify, recruit, and provide technical support to five to eight Wisconsin counties. Key stakeholders from the State Division of Mental Health and Substance Abuse Services, county governments, and appropriate representatives of state and community-based psychiatric facilities will also be invited to participate in the collaborative.

The University of Wisconsin (NIATx) will draw on its experience in designing change strategies and building learning collaboratives in behavioral health to change practices in counties committed to reducing unnecessary/inappropriate inpatient admissions and readmissions. Lessons learned from the collaborative initiative will be used to help reduce readmissions statewide.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	19.87	21.58	20	30.26	66.09
Numerator	1,756	2,037	--	2,717	--
Denominator	8,839	9,441	--	8,979	--

Table Descriptors:

**Goal:** Decrease the rate of readmission to psychiatric hospitals within 180 days. (National Outcome Measure)

**Target:** Decrease the rate of readmission to psychiatric hospitals within 180 days by approximately one percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of adults discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 180 days.

**Measure:** Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 180 days.  
Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** This is a national outcome measure required by CMHS. The data to monitor readmissions to psychiatric hospitals for adults will be taken directly from URS Data Table 21, which states are required to report in the annual MHBG Implementation Report.

**Significance:** Community-based treatment is at the core of the Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of approximately one percent in the readmission rate over the FFY 2009 period. There are a number of programs that will likely have an impact on this indicator. Expanding services in three program areas over the next two years will reduce the rate of readmission to psychiatric hospitals by making more services more readily available in the community.

The availability of Community Support Programs (CSP) services will remain a primary strategy to reducing readmissions. In many cases, the next step going down the continuum of care for consumers from psychiatric hospitals is a CSP. Since CSPs are available in a majority of Wisconsin counties now, they will continue to play an important role in decreasing psychiatric hospital use.

In FFY 2009-2010, Wisconsin plans to offer \$100,000 in MHBG in start-up funds to any of those counties that are interested in building their capacity to become a certified CSP provider. Counties will be notified about the availability of the funds, and technical assistance made available to those counties.

Increasing the number of crisis programs through five multi-county initiatives also has served to reduce the number of inpatient placements, including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years.

Wisconsin continues to increase the number of certified CCS programs in the state on an annual basis by providing \$100,000 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four were added in FFY 2008. The CCS benefit is for both adults and children. Increasing the number

of counties that provide CCS benefits will bring services to more adults in new areas of the state. Twenty-nine counties have certified CCS programs as of November 2009.

When individuals are discharged from psychiatric hospitals, these are the expected increased service options that will be available to them. Becoming engaged with these service/program options after discharge from a psychiatric hospital should reduce the incidence of readmissions.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

Target not achieved. The number and cost of care for the persistent and severely mentally ill continues to grow in Wisconsin. Residents of Wisconsin also have a higher rate of use of state psychiatric hospitals and community inpatient psychiatric services compared to the national average. At the same time, state and county budgets are shrinking due to reduced revenue. The Governor's Budget includes several measures aimed at reducing institutionalization and expanding community treatment for people with mental illness. As of January 2010, Wisconsin counties will be required to contribute to the cost of care for children and elderly patients at state psychiatric hospitals. This change will increase the fiscal responsibility of Wisconsin counties at a time when county administrators are cutting services or raising taxes to offset reduced revenues.

The aim of the Wisconsin Mental Health Collaborative is to reduce unnecessary/inappropriate admissions and readmissions to inpatient facilities among the state's persistent and severely mentally ill. Experts in quality improvement from the University of Wisconsin (NIATx) are partnering with the State Division of Mental Health and Substance Abuse Services to identify, recruit, and provide technical support to five to eight Wisconsin counties. Key stakeholders from the State Division of Mental Health and Substance Abuse Services, county governments, and appropriate representatives of state and community-based psychiatric facilities will also be invited to participate in the collaborative.

The University of Wisconsin (NIATx) will draw on its experience in designing change strategies and building learning collaboratives in behavioral health to change practices in counties committed to reducing unnecessary/inappropriate inpatient admissions and readmissions. Lessons learned from the collaborative initiative will be used to help reduce readmissions statewide.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	6	6	6	7	116.67
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of evidence-based practices for adults. (National Outcome Measure)

**Target:** To facilitate the use of evidence-based practices for adults by funding their implementation and disseminating training resources in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of evidence-based practices used for adults in the state in FFY 2009.

**Measure:** Number of evidence-based practices used for adults in the state in FFY 2009.

**Sources of Information:** Division of Mental Health and Substanct Abuse (DMHSAS) records.

**Special Issues:** The first task for Wisconsin is collecting reliable statewide data on the use of evidence-based practices (EBP). Wisconsin is designing and implementing a method for assessing EBP use in FFY 2010. Defining and identifying EBPs will be a part of this effort.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2009, there are 78 CSPs in Wisconsin which meet the standards for certification established by DMHSAS. Wisconsin will continue to expand the use of CSPs by funding new counties for start-up and certification costs. Implementation of CSPs is based on the ACT model.

In FFY 2007, Wisconsin began implementation of Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) in five counties by awarding MHBG-funded contracts. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation. Kenosha County reports that in 2008-2009, their local CSP and CCS implemented a Supportive Housing Program and that they are implementing IMR. Jefferson County reports that their CSP team is implementing a family Psycho Education group, IDDT, Supported Employment, IMR, and Seeking Safety groups for both men and women. Brown and Marathon counties are implementing IDDT, and Richland County is implementing IMR.

The EBP grants were awarded in 2008 to help additional counties continue their implementation and quality improvement work. The DMHSAS runs the EBP grants in three-year cycles. This is a core part of the Wisconsin transformation plan. Each county is required to compete for funding and they are required to do three activities. The activities include rewriting their forms, policies and procedures for intake into their community programs to ensure their system is consumer and family driven; implement a QI team for on-going TQI, using a data driven typology promoted by the Department for all QI efforts, and ; implement at least one evidence-based practice in their community programs beyond ACT. All of these activities are required to be sustainable after the three-year cycle of funding is ended. In 2008, three of the counties entered their last year of funding, and two counties entered their second year of funding. These counties are becoming experts in their chosen EBP and will be utilized as mentors within their region as part of the DMHSAS plan for dissemination of evidence-based practices.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	23.48	0	N/A	N/A	N/A
Numerator	1,301	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

- Goal:** To facilitate the use of Supported Housing as an evidence-based practice for adults.
- Target:** To increase the use of Supported Housing as an evidence-based practice for adults by one percent in FFY 2009.
- Population:** Adults with SMI.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults receiving Supported Housing as an evidence-based practice in the Community Support Programs (CSPs) in FFY 2009.
- Measure:** Numerator: Number of adults receiving Supported Housing as an evidence-based practice in the CSPs in FFY 2009.  
Denominator: Number of adults receiving services through CSPs in FFY 2009.
- Sources of Information:** Community Support Program (CSP) Monitoring Report.
- Special Issues:** A CSP survey began implementation in 2007. This survey provides information on how many EBPs are being implemented through CSPs in the state and how many individuals are receiving EBPs.
- Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.
- Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties chose Illness Management and Recovery (IMR). None of the current five counties chose to implement Supported Housing at this time. The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties who will also be given the option to choose which EBP will best meet the needs of their consumers, including Supported Housing. The first three-year grants ended after FFY 2008.

In addition, the BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of supported housing, but the degree to which is being implemented with complete fidelity to the Supported Housing model is unknown. Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine whether some local providers are already using Supported Housing and thus the reporting for this EBP could change in the future.

The data for this indicator on the number of individuals receiving EBPs through CSPs is

reported by counties. The degree of fidelity in EBP implementation is unknown, however, Wisconsin is working toward full fidelity through expanding EBP pilot programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	23.17	0	N/A	N/A	N/A
Numerator	1,284	N/A	--	N/A	--
Denominator	5,541	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of Supported Employment as an evidence-based practice for adults.

**Target:** To increase the use of Supported Employment as an EPB for adults served through Community Support Programs by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving Supported Employment services through Community Support Programs in FFY 2009.

**Measure:** Numerator: The number of adults receiving Supported Employment services through CSPs in FFY 2009.  
Denominator: The number of adults serviced through CSPs in FFY 2009.

**Sources of Information:** Community Support Program (CSP) Monitoring Report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** The BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBP's and EBP categorizations exist in the field, including distinguishing EBP's from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBP's are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of supported employment, but the degree to which is being implemented with complete fidelity to the Supported Employment model is unknown. Wisconsin also has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine which local providers are already using Supported Employment and thus the reporting for this EBP could change in the future. Presently, the CSPs self-report on the number of individuals receiving the Supported Employment EBP through a web-based CSP survey. This is the data currently being reported for this indicator.

In FFY 2007, Wisconsin began implementation of Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) in five pilot counties by awarding MHBG-funded contracts. Three counties are implementing IDDT and two counties are implementing IMR. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation. Kenosha County reports that in 2008 their local CSP and CCS programs served eight residents in a local Supportive Housing Program. Jefferson County reports their CSP team has one employment specialist, who is fully integrated into the mental health treatment of consumers and that they implemented a Family Psycho education group from 2004 through 2007.

The EBP grants were awarded in 2008 to help additional counties continue their implementation and quality improvement work. The DMHSAS runs the EBP grants in three-year cycles. This is a core part of the Wisconsin transformation plan. Each county is required to compete for funding and they are required to do three activities. The activities include rewriting their forms, developing policies and procedures for intake into their community programs to ensure their system is consumer and family driven; implementing a QI team for on-going TQI, using a data driven typology promoted by the Department for all QI efforts; and implementing at least one evidence based practice in their community programs beyond ACT. All of these activities are required to be sustainable after the three year cycle of funding is ended. In 2008 three of the counties entered their last year of funding, and two counties entered their second year of funding. These counties are becoming the experts in their chosen EBP and will be used as mentors within their region as part of the DMHSAS plan for dissemination.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	87.89	0	N/A	N/A	N/A
Numerator	4,869	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the use of ACT as an evidence-based practices for adults with an SMI. (National Outcome Measure)

**Target:** To increase the use of ACT as an evidence-based practices for adults served through Community Support Programs (CSP) by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving evidence-based practices in CSPs in FFY 2009.

**Measure:** Numerator: Number of adults receiving Assertive Community Treatment (ACT) through CSPs in FFY 2009.  
Denominator: Number of adults served through CSPs in FFY 2009.

**Sources of Information:** Community Support Program (CSP) Monitoring report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2009, there are 78 CSPs in Wisconsin which meet the standards for certification established by the DMHSAS. Wisconsin will continue to expand the use of CSPs by funding new counties for start-up and certification costs. The implementation of CSPs is based on the ACT model.

The BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of supported employment, but the degree to which is being implemented with complete fidelity to the Supported Employment model is unknown. Wisconsin also has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine which local providers are already using ACT and thus the reporting for this EBP could change in the future. Presently, the CSPs self-report on the number of individuals receiving the ACT EBP through a web-based CSP survey. This is the data currently being reported for this indicator.

In FFY 2007, Wisconsin began implementation of Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) in five pilot counties by awarding MHBG-funded contracts. Three counties are implementing IDDT and two counties are implementing IMR. Counties have been using the SAMHSA EBP toolkit materials to guide

their implementation. Kenosha County reports that in 2008 their local CSP and CCS programs served eight residents in a local Supportive Housing Program. Jefferson County reports that their CSP team has one employment specialist, who is fully integrated into the mental health treatment of consumers and that they have implemented a Family Psycho education group from 2004 through 2007.

The EBP grants were awarded in 2008 to help additional counties continue their implementation and quality improvement work. The DMHSAS runs the EBP grants in three-year cycles. This is a core part of the Wisconsin transformation plan. Each county is required to compete for funding and they are required to do three activities. The activities include rewriting their forms, policies and procedures for intake into their community programs to ensure their system is consumer and family driven; implement a QI team for on-going TQI, using a data driven typology promoted by the Department for all QI efforts, and; implement at least one evidence based practice in their community programs beyond ACT. All of these activities are required to be sustainable after the three year cycle of funding is ended. In 2008 three of the counties entered their last year of funding, and two counties entered their second year of funding. These counties are becoming the experts in their chosen EBP and will be used as mentors within their region as part of the DMHSAS plan for dissemination.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	7.62	0	N/A	N/A	N/A
Numerator	422	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the use of Family Psychoeducation for adults with severe mental illness.

**Target:** To increase the use of Family Psychoeducation by one percent for adults with severe mental illness served in Community Support Programs in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving Family Psychoeducation as an evidence-based practice in Community Support Programs (CSPs) in FFY 2009.

**Measure:** Numerator: Number of adults receiving Family Psychoeducation as an EBP in CSPs in FFY 2009.  
Denominator: Number of adults receiving services through CSPs in FFY 2009.

**Sources of Information:** Community Support Program (CSP) Monitoring Report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin's SMHA began efforts to implement Family Psychoeducation for the first time in CY 2007. In its annual MHBG-funded contract with the state NAMI-Wisconsin, the BPTR added Family Psychoeducation trainings to the NAMI-Wisconsin work plan. NAMI-Wisconsin agreed to train their staff to become experts on Family Psychoeducation and then train local providers across the state to implement this EBP in their county. NAMI-Wisconsin began in CY 2007 by training their staff and providing some trainings to local providers near the end of the year. Wisconsin will be including targets in its future State MH Plans.

In addition, the DMHSAS formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the DMHSAS. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBP's will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing services similar to Family Psychoeducation, but the degree to which is being implemented with complete fidelity to the Family Psychoeducation model is unknown. Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine whether some local providers are already using Family Psychoeducation and thus the reporting for this EBP could change in the future.

The data for this indicator on the number of individuals receiving EBPs through CSPs is reported by counties. The degree of fidelity in EBP implementation is unknown, however, Wisconsin is working toward full fidelity through expanding EBP pilot programs.

**Target Achieved or** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been

**Not Achieved/If** reported for 2009.  
**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	21.55	0	N/A	N/A	N/A
Numerator	1,194	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the use of Integrated Dual Disorder Treatment (IDDT) as an evidence-based practice for adults.

**Target:** To increase the use of IDDT as an evidence-based practice for adults by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving IDDT as an evidence-based practice in the state in FFY 2009.

**Measure:** Numerator: Number of adults receiving IDDT as an evidence-based practice through Community Support Programs (CSPs) in FFY 2009.  
Denominator: Number of adults served through CSPs in FFY 2009.

**Sources of Information:** Community Support Program (CSP) Monitoring Report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties are chose Illness Management and Recovery (IMR). The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers.

In addition, the BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of IDDT, but the degree to which is being implemented with complete fidelity to the IDDT model is unknown. Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine whether some local providers are already using IDDT and thus the reporting for this EBP could change in the future.

The data for this indicator on the number of individuals receiving EBPs through CSPs is reported by counties. The degree of fidelity in EBP implementation is unknown, however, Wisconsin is working toward full fidelity through expanding EBP pilot programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	38.09	0	N/A	N/A	N/A
Numerator	2,110	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the use of Illness Self-Management as an evidence-based practice for adults.

**Target:** To increase the use of Illness Self-Management as an evidence-based practice for adults in Community Support Programs (CSPs) by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of adult consumers receiving Illness Self-Management services through Community Support Programs in FFY 2009.

**Measure:** Numerator: The number of adults receiving Illness Self-Management services in Community Support Programs (CSP) in FFY 2009.  
Denominator: The number of adults receiving services through CSPs in FFY 2009.

**Sources of Information:** The Community Support Program (CSP) Monitoring Report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBP's for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties are chose Illness Management and Recovery (IMR). The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers. The first three-year grants ended after FFY 2008.

In addition, the BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of supported housing, but the degree to which is being implemented with complete fidelity is unknown. Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices.

The data for this indicator on the number of individuals receiving EBPs through CSPs is reported by counties. The degree of fidelity in EBP implementation is unknow, however, Wisconsin is working toward full fidelity through expanding EBP pilot programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	43.09	0	N/A	N/A	N/A
Numerator	2,387	N/A	--	N/A	--
Denominator	5,540	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the use of Medication Management as an evidence-based practice for adults.

**Target:** To increase the use of Medication Management as an evidence-based practice for adults in Community Support Programs (CSPs) by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving Medication Management as an evidence-based practice in CSPs in FFY 2009.

**Measure:** Numerator: Number of adults receiving Medication Management as an evidence-based practice through Community Support Programs (CSP) in FFY 2009.  
Denominator: Number of adults receiving services through Community Support Programs (CSP) in FFY 2009.

**Sources of Information:** Community Support Program (CSP) Monitoring Report.

**Special Issues:** Implementation of a survey of EBPs supported through Community Support Programs (CSPs) in Wisconsin began in 2007. A web-based data system collects the number of individuals receiving EBPs through CSPs each year. DMHSAS is supporting fidelity through five initial EBP pilot projects that will be replicated in additional counties.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties are chose Illness Management and Recovery (IMR). The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers. The first three-year grants ended after FFY 2008.

In addition, the BPTR formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BPTR. A variety of definitions of EBP's and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of medication management, but the degree to which is being implemented with complete fidelity to the medication management model is unknown. Another example is that Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices.

The data for this indicator on the number of individuals receiving EBPs through CSPs is reported by counties. The degree of fidelity in EBP implementation is unknow, however, Wisconsin is working toward full fidelity through expanding EBP pilot programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown. Data on number of individuals receiving EBPs through CSPs has not yet been reported for 2009.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	58.21	63.14	65	N/A	N/A
Numerator	195	233	--	N/A	--
Denominator	335	369	--	N/A	--

Table Descriptors:

**Goal:** Improve client perception of care. (National Outcome Measure)

**Target:** To increase the percentage of consumers satisfied with the outcomes of their treatment by two percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adult consumers responding to the satisfaction survey with a "positive" response about the outcome of their treatment as measured by the outcomes scale on the survey in FFY 2009.

**Measure:** Numerator: The number of adults with a "positive" response about the outcome of their treatment measured by the Outcomes scale in FFY 2009.  
Denominator: The total number of adults responding to the survey in FFY 2009.

**Sources of Information:** Mental Health Statistical Improvement Programs Adult Satisfaction Survey (MHSIP).

**Special Issues:** A sample of consumers is surveyed throughout the state. The sampling must be representative of the state and must be monitored. If the sample becomes unbalanced based on important demographic or geographic characteristics, a modified sampling approach will be used to correct the balance.

**Significance:** Without understanding the consumer's perspective on their service experience, a crucial piece of data is missing in understanding the effectiveness of mental health services.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin collects client perception of care data using the Mental Health Statistical Improvement Program's (MHSIP) adult and youth consumer satisfaction surveys. Funding from the Data Infrastructure Grant (DIG) for FFY 2010 has been budgeted to fund the administration of the satisfaction surveys and DIG funds were budgeted for administering the survey in FFY 2009 also.

Wisconsin is currently analyzing the data from the MHSIP surveys to determine which services or programs have the lowest satisfaction scores and for what reason.

It is the intent of the DMHSAS to move towards an outcome-based, consumer-focused system where quality improvement is built into the programs at the local level. To that end, Wisconsin will develop mechanisms to collect outcome data and quality indicators and intends to change the way in which we evaluate the success of services and supports provided. A functional screen that local agencies can use to develop indicators from has been developed, so that quality improvement efforts can be data driven. Wisconsin has also begun measuring how recovery-oriented mental health service systems are by using the Recovery-Oriented System Indicators (ROSI) survey. Results from the ROSI can be used to direct quality improvement efforts to improve the use of recovery principles in the operation of service systems. This QI effort has begun in five counties in FFY 2008 and will be offered to an expanding number of counties in the coming year to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance. In 2007, money from the mental health block grant increase was offered to additional county community programs to begin use of the functional screen for CSP (It is now optional for CSP pending a rule change). Currently about 40 counties use the screen for CSP in addition to its mandatory use in CCS and COP. This has allowed additional counties in FFY 2009 to collect data at the local level that they can use as indicators of annual progress in recovery.

**Target Achieved or Not Achieved/If Not, Explain Why:** MHSIP survey results for FFY 2009 will be available in April of 2010.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	28.56	27.67	29	28.04	96.69
Numerator	3,926	3,815	--	3,515	--
Denominator	13,746	13,789	--	12,537	--

Table Descriptors:

**Goal:** Increase or retain employment for mental health consumers. (National Outcome Measure)

**Target:** To increase the percentage of consumers with new or continued employment by one percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** The percentage of adults with SMI in the labor force who are employed in FFY 2009.

**Measure:** Numerator: Number of adults 18 and older with SMI who are employed in FFY 2009.  
Denominator: Number of adults 18 and older with SMI who are employed, unemployed, or not in the labor force in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** This indicator focuses on employment for all adults including those who are employed, unemployed, or not in the labor force. Adults who are not in the labor force are disabled, retired, homemakers, care-givers, etc. Unemployed refers to persons who are looking for work but have not found employment. Employed means competitively employed, part-time or full-time, including supported employment and transitional employment. Informal labor for cash is counted as employed. The employment status is reported from the most recent data available within the applicable year.

**Significance:** Employment is one of the major areas of functioning in life. It serves as an indicator of an individual’s ability to support him or herself as well as others. It also serves as an indicator of how well an individual is able to apply the knowledge and skills he/she has. Employment can also serve as an indicator of how well an individual is integrated into the community.

**Activities and strategies/ changes/ innovative or exemplary model:** Both the CCS and CSP programs are required to assess employment as a domain, to determine if the person wants to work or go to school and requires help to do so. DMHSAS works closely with the Pathways to Independence program funded by the Medicaid Infrastructure Grant (MIG) and in partnership with MIG staff are implementing the following strategies to encourage and foster better employment opportunities for people with mental health issues: funding a peer specialist development position to foster employment opportunities within the mental health system for peers; development of a training curriculum for peers by peers to educate consumers in setting vocational goals, writing resumes and wellness on the job; and education of employers regarding stigma in the workplace and how to deal with it. In addition Pathways to Independence is developing regionally based vocational specialists for people with disabilities and is training vocational specialists to do outreach in each community. We see training the case managers in how to manage benefits and preserve Medicaid while being able to work as critical to consumers who are confused and afraid of losing health insurance by working.

In addition, both CSP and CCS have strong focus on employment and DMHSAS is developing additional indicators for agencies from the functional screen to help develop stronger supported employment programs at the local level and allow the state to monitor on a quarterly basis.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target very nearly achieved. The target goal was achieved by 96.69 percent. This is a very positive outcome. Wisconsin will continue with the activities listed above to continue improving outcomes.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	50	30.77	26	N/A	N/A
Numerator	18	4	--	N/A	--
Denominator	36	13	--	N/A	--

Table Descriptors:

- Goal:** Decrease criminal justice involvement for mental health consumers. (National Outcome Measure)
- Target:** To decrease the percentage of adult mental health consumers involved with the criminal justice system by four percent annually.
- Population:** Adults with SMI.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** The percentage of adults with SMI with no arrest in FFY 2009 after being arrested in FFY 2008.
- Measure:** Numerator: Number of adults 18 years and older with SMI who had no arrests in FFY 2009 after being arrested in FFY 2008.  
Denominator: Number of adults 18 years and older with SMI who were arrested in FFY 2008
- Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) adult satisfaction survey.
- Special Issues:** The MHSIP adult satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about criminal justice involvement to the survey as a method of collecting consistent data across states on this topic. Wisconsin's MHSIP survey is a random sample of all adult mental health consumers with SMI that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be representative for all individuals with SMI who are served in the public mental health system in the state. For this indicator, adult consumers describe if they were arrested in either FFY 2008 or FFY 2009. The indicator focuses on adults arrested in FFY 2008 to see if they were able to avoid being arrested again in FFY 2009.
- Significance:** Involvement with the criminal justice system is sometimes associated with mental health disorders. While consumers are receiving mental health services, it is expected that involvement with the criminal justice system would decrease for consumers who had been involved with the system in the past. For the majority of consumers who have never been involved with the criminal justice system, it is expected that they would not have any new involvement with the criminal justice system while receiving mental health services.
- Activities and strategies/ changes/ innovative or exemplary model:** The action plan for 2010 is two-fold. The DMHSAS will work with existing counties who have a mental health court to act as mentors to other counties who are willing to collaborate on the development of a mental health court, modeled on the drug court concepts. In addition, DMHSAS will examine additional data from the mental health functional screen which targets the MH population who need services and supports beyond outpatient services. This population is the most susceptible to criminal justice involvement and close examination of this data will allow the DMHSAS to work with those counties where a high proportion of criminal justice involvement may indicate the need for more services and supports including co-occurring supports for dually diagnosed individuals. Improving the data sources for the population that is most susceptible, and focusing on a larger proportion of that population may indicate additional technical assistance as we become more sophisticated in targeting populations in need.
- Target Achieved or Not Achieved/If** Results of the 2009 MHSIP survey will be available in April of 2010.

**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1.88	1.54	6.50	N/A	650
Numerator	376	314	--	N/A	--
Denominator	20,000	20,399	--	N/A	--

Table Descriptors:

**Goal:** Increase stability in housing. (National Outcome Measure)

**Target:** To increase the number of adults with SMI who are homeless that receive mental health services by five percent annually from FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of adults with SMI who are homess who receive mental health services in FFY 2009.

**Measure:** Numerator: Number of adults with SMI who are homeless who receive mental health services in FFY 2009 minurs the number of adults with SMI who are homess who receive mental health services in FFY 2008.  
Denominator: Number of adults with SMI who are homeless who receive mental health services in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** A memo is sent from DMHSAS annually to every county outlining the expenditure priorities for the portion of the MHBG sent directly to counties. The use of funds to serve individuals who are homeless is described as a priority in the memo. Counties receive their allocated FFY 2009 MHBG funds in CY 2008. Counties are required to report their budget plan and actual expenditures so this priority can be monitored.

**Significance:** Individuals who are homeless are typically an underserved population with high levels of need.

**Activities and strategies/ changes/ innovative or exemplary model:** Since 2005, Wisconsin has issued an annual memo to all counties describing a priority to improve efforts to serve persons with serious mental illness who are homeless. The memo informs counties that they must prioritize serving individuals who are homeless with their MHBG funds. The same memo was issued in 2008 informing counties to continue to prioritize individuals who are homeless for mental health services with the use of their FFY 2009 MHBG funds. In addition to serving individuals who are homeless with a mental illness, the counties were instructed to prioritize the submission of quality data describing individuals who are homeless who receive mental health services. Counties have the ability to record mental health service data on individuals who are homeless through the statewide Human Services Reporting System. In the past, there has been an underutilization of the codes indicating homelessness. By making this a priority, DMHSAS anticipates an increase in mental health service provision to individuals who are homeless and in the reporting of services for homeless individuals to the state. Improvements in data reporting, as required in the memo sent to all Wisconsin counties, will allow the Department and the counties to understand where services could be improved and to take action to make the needed improvements.

The Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) has a memorandum of understanding with the Department of Commerce that guarantees a percentage of the federal mental health block grant funding goes toward programs specifically for the prevention and/or diversion of homelessness for people with mental illness. The funding level is currently \$74,000 per year and is distributed in a competitive process with a three year cycle.

DMHSAS collaborates on the award amount annually with the Department of Commerce. For the last three years the award has gone to Waukesha County for their innovative approach to outreach. Waukesha has developed a diversion program to identify individuals with mental health and co-occurring substance abuse disorders, who are incarcerated in the local county jail. Once identified as needing care coordination upon release, planning is done with the population to ensure follow-up with a mental health professional, temporary housing and initial benefits applications. The goal of the program is to prevent recidivism by breaking the cycle of release and re-arrest due to lack of basic needs and treatment. Currently, Waukesha County provides one full-time position for the Jail Transition Program, and the MHBG funding provides an additional part-time position. The part-time position is housed in the jail and the full-time counseling position is at the county mental health agency where follow-up is done, benefits applied for, temporary housing is arranged and mental health services provided. Grant funding is proposed for one additional year.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	64.26	64.36	66	N/A	N/A
Numerator	214	242	--	N/A	--
Denominator	333	376	--	N/A	--

Table Descriptors:

**Goal:** Increase social supports/social connectedness. (National Outcome Measure)

**Target:** To increase the percentage of mental health consumers with social supports by two percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of adults with SMI who have social supports in their community in FFY 2009.

**Measure:** Numerator: Number of adults 18 and older with SMI who agree they have social supports to rely on in their community in FFY 2009.  
Denominator: Number of adults 18 and older with SMI responding about the degree of social supports they have in their community on the MHSIP satisfaction survey in FFY 2009.

**Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) adult satisfaction survey.

**Special Issues:** The MHSIP adult satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about social supports to the survey as a method of collecting consistent data across states on this topic. Wisconsin's MHSIP survey is a random sample of all adult mental health consumers with SMI that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value in the indicator table is meant to be representative for all individuals with SMI who are served in the public mental health system in the state. Survey respondents report how much they agree or disagree on a 5-point scale for four survey questions to generate an overall scale score for the availability of social supports to them.

**Significance:** A consumer's ability to successfully complete treatment and maintain that success after completing services can be enhanced by having social supports within their friends, family, and/or community.

**Activities and strategies/ changes/ innovative or exemplary model:** In 2008, the DMHSAS started a new initiative to promote person-centered planning with a focus on the development of community and informal supports as part of the recovery plan for all individuals receiving services. This aligns with the new requirements for person centered planning from CMS in the new proposed psycho-social rehabilitation (PSR) rules, and also meets the NFC Goal 2, that mental health care is consumer and family driven. This initiative will continue through FFY 2010.

DMHSAS wrote and received a competitive grant to CMS to take person-centered planning statewide for all individuals in public programs in both CCS and CSP. While it is a requirement currently in CCS, it is not in the older clinical guidelines for CSP. Given the new PSP requirements this is the ideal time to promote training and technical assistance for person- centered planning for all mental health programs in Wisconsin.

Aside from a person-centered approach, the Comprehensive Community Services (CCS) benefit provides an expanded choice of MA-funded mental health services. Wisconsin continues to increase the number of certified CCS programs in the state on an annual basis by providing \$100,000 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four were added in FFY 2008. The CCS benefit is for both adults and children. Some of the state's CST programs

are beginning to integrate the CCS benefit within their programs and Wisconsin have educated additional counties to do the same in FFY 2009-2010. Increasing the number of counties that provide CCS benefits will bring services to more children in new areas of the state. Twenty-nine counties have certified CCS programs as of November 2009.

Wisconsin also funds 78 Community Support Programs (CSP) to serve severely mentally ill individuals in the community. Community Support Programs facilitate social supports and contacts in the community through rehabilitation services. Along with the required treatment services, the array of rehabilitation services available to CSP consumers includes: vocational assessment; job development and vocational supportive counseling; social and recreational skill training; supportive housing and individualized support; and training and assistance in all activities of daily living.

**Target Achieved or Not Achieved/If Not, Explain Why:** Results of the 2009 MHSIP survey will be available in April of 2010.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	59.70	64.92	67	N/A	N/A
Numerator	200	248	--	N/A	--
Denominator	335	382	--	N/A	--

Table Descriptors:

**Goal:** Improved level of functioning. (National Outcome Measure)

**Target:** To increase the percentage of consumers with improved functioning by three percent annually.

**Population:** Adults with SMI.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** The percentage of adults with SMI who report improved functioning as a result of their mental health services in FFY 2009.

**Measure:** Numerator: Number of adults 18 and older with SMI who report generally improved functioning as a result of mental health services received through the public mental health system in FFY 2009.  
Denominator: Number of adults 18 and older with SMI responding about their general ability to function on the MHSIP satisfaction survey in FFY 2009.

**Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) adult satisfaction survey.

**Special Issues:** The MHSIP adult satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about general functioning to the survey as a method of collecting consistent data across states on this topic. Wisconsin's MHSIP survey is a random sample of all adult mental health consumers with SMI that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be an indicator of adult criminal justice involvement for the entire state. Survey respondents report how much they agree or disagree on a 5-point scale with five survey questions to generate an overall scale score for how their ability to function has changed as a direct result of the mental health services they've received in the last year. The survey questions address areas of general functioning such as "My symptoms are not bothering me as much" and "I am better able to take care of my needs."

**Significance:** One of the primary goals of mental health services is to improve the consumer's ability to cope with their mental health disorder and function within his/her different domains of life.

**Activities and strategies/ changes/ innovative or exemplary model:** The Wisconsin Department of Health Services has, over the last several years focused on the development of a series of functional screens for its core programs. There is an adult screen and children's screen for long term care and associated programs, which determines functional levels of need and eligibility. In addition, there is a children's screen and adult screen for people with mental health and substance abuse issues that determines an individual's level of need for services and supports beyond outpatient care. This latter screen is mandatory for CCS and is being heavily promoted for use in CSP. It will be mandatory for CSP as soon as the administrative code is changed to add it. The screen is done annually and contains a series of functional measurements for self care, self management and risk that can be used to indicate to agency if an individual has progressed over the last year, or whether the agency is progressing in the aggregate with promotion of functional independence. It is used as a quality improvement tool by the state and in the next year we intend to produce reports back to the county agencies that will indicate to them their progress in relation to other agencies with similar populations. They will be offered technical assistance by DMHSAS in any of the areas where they are falling below the state average. So for example, if in the aggregate an agency is showing poor progress with improvement of functioning in symptom management, we will promote the use of Illness

Management and Recovery as an EPB that works well, and offer technical assistance for its implementation. In addition, the screen can be sorted locally by case manager and local supervisors can clearly see improvement in functioning of individual consumers by case manager. They will be encouraged to use this data to offer technical assistance to case managers where improved functioning seems to be a challenge for certain consumers.

DMHSAS is slowly building a data base of consumer functioning in the aggregate state wide and hope to be able to produce report cards by agency that will assist them in their own QI efforts for key functional areas. These combined efforts should improve consumer responses on the survey regarding their perception of how they are functioning.

**Target Achieved or Not Achieved/If Not, Explain Why:** Results of the 2009 MHSIP survey will be available in April of 2010.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Access to MH services for adults who are homeless.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	10.89	3.79	5	6.72	177.30
Numerator	202	78	--	122	--
Denominator	1,854	2,056	--	2,134	--

Table Descriptors:

**Goal:** Improve access to mental health services for adults who are homeless.

**Target:** Increase the number of adults with severe mental illness (SMI) who are homeless that receive mental health services by one percent in FFY 2009.

**Population:** Adults with SMI.

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** The percentage of adults with SMI who are homeless who receive mental health services in FFY 2009.

**Measure:**  
 Numerator: The number of adults with SMI who are homeless who receive mental health services in FFY 2009 minus the number of adults with SMI who are homeless how receive mental health services in FFY 2008.  
 Denominator: The number of adults with SMI who are homeless who receive mental health services in FFY 2008.

**Sources of Information:** Human Services Reporting System (HSRS).

**Special Issues:** A memo is sent from DMHSAS annually to every county outlining the expenditure priorities for the portion of the MHBG sent directly to counties. The use of funds to serve individuals who are homeless is described as a priority in the memo. Counties receive their allocated FFY 2009 MHBG funds in CY 2008. Counties are required to report their budget plan and actual expenditures so this priority can be monitored.

**Significance:** Individuals who are homeless are typically an underserved population with a high level of need.

**Activities and strategies/ changes/ innovative or exemplary model:** Since 2005, Wisconsin has issued an annual memo to all counties describing a priority to improve efforts to serve persons with serious mental illness who are homeless. The memo informs counties that they must prioritize serving individuals who are homeless with their MHBG funds. The same memo will be issued in 2008 informing counties to continue to prioritize individuals who are homeless for mental health services with the use of their FFY 2009 MHBG funds. In addition to serving individuals who are homeless with a mental illness, the counties were instructed to prioritize the submission of quality data describing individuals who are homeless who receive mental health services. Counties have the ability to record mental health service data on individuals who are homeless through the statewide Human Services Reporting System. In the past, there has been an underutilization of the codes indicating homelessness. By making this a priority, DMHSAS anticipates an increase in mental health service provision to individuals who are homeless and in the reporting of services for homeless individuals to the state. Improvements in data reporting, as required in the memo sent to all Wisconsin counties, will allow the Department and the counties to understand where services could be improved and to take action to make the needed improvements.

The Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) has a memorandum of understanding with the Department of Commerce that guarantees a percentage of the federal mental health block grant funding goes toward programs specifically for the prevention and/or diversion of homelessness for people with mental illness. The funding level is currently \$74,000 per year and is distributed in a competitive process with a three year cycle.

DMHSAS collaborates on the award amount annually with the Department of Commerce. For the last three years the award has gone to Waukesha County for their innovative approach to outreach. Waukesha has developed a diversion program to identify individuals

with mental health and co-occurring substance abuse disorders, who are incarcerated in the local county jail. Once identified as needing care coordination upon release, planning is done with the population to ensure follow-up with a mental health professional, temporary housing and initial benefits applications. The goal of the program is to prevent recidivism by breaking the cycle of release and re-arrest due to lack of basic needs and treatment. Currently, Waukesha County provides one full-time position for the Jail Transition Program, and the MHBG funding provides an additional part-time position. The part-time position is housed in the jail and the full-time counseling position is at the county mental health agency where follow-up is done, benefits applied for, temporary housing is arranged and mental health services provided. Grant funding is proposed for one additional year.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Access to MH services for adults with a SMI in rural areas.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	87.93	87.93	88	86.21	98.04
Numerator	51	51	--	50	--
Denominator	58	58	--	58	--

Table Descriptors:

**Goal:** To increase access to mental health services for adults with a SMI in rural areas.

**Target:** Increase annually the number of rural counties with a CSP by one percent in FFY 2009.

**Population:** Rural Adults who have a SMI.

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** The percentage of rural counties with certified Community Support Programs (CSP).

**Measure:** Numerator: The number of rural counties with certified CSPs in FFY 2009.  
Denominator: The number of rural counties in FFY 2009.

**Sources of Information:** State data on program certification from the Division of Quality Assurance.

**Special Issues:** Wisconsin currently has a shortage of psychiatrists and other mental health workers in rural areas. Some counties do not have the infrastructure to support a CSP, or a full-time psychiatrist. Some of these rural areas are combining programs and sharing resources across counties to provide services. Another issue for mental health consumers in rural areas is a lack of transportation; this is where tele-health can be very useful.

**Significance:** Much of Wisconsin is rural and access to mental health services within these areas remains a significant need and priority.

**Activities and strategies/ changes/ innovative or exemplary model:** DMHSAS worked with Iron and Walworth Counties to help them get certified. Of the eight counties remaining without a CSP, seven of them are rural counties. Wisconsin plans to continue to try to increase the number of certified CSPs in the rural areas of the state on an annual basis by providing \$100,000 in MHBG for program start-up funds to interested counties. The start-up funds are intended to help counties build the capacity to be a certified CSP provider. Certified CSPs are able to claim MA funding for consumer services which provides an important source of funding for program sustainability. Increasing the number of counties that have a CSP will bring services to more adults in new areas of the state.

In FFY 2010, Wisconsin plans to recruit and prepare another rural county to develop a certified CSP. Wisconsin will use its FFY 2006 assessment of counties that are ready and willing to pursue CSP certification to determine which county to work with in FFY 2010.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target very nearly achieved. Wisconsin will continue the above activities to increase access to mental health services for adults with SMI in rural area.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Expansion of the mental health and co-occurring functional screen.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	36.11	47.22	52	61.11	129.42
Numerator	26	34	--	44	--
Denominator	72	72	--	72	--

Table Descriptors:

**Goal:** Increase access to, and appropriateness of, mental health services by expanding the use of the MH/SA Functional Screen. (State Transformation Outcome Measure)

**Target:** To increase the use of the MH/SA Functional Screen in additional counties by five percent in FFY 2009.

**Population:** Adults with Serious Mental Illness and co-occurring substance abuse issues.

**Criterion:** 2:Mental Health System Data Epidemiology

**Indicator:** The percentage change in the number of counties implementing the MH/AODA Functional Screen.

**Measure:** Numerator: Number of counties implementing the MH/SA Functional Screen in FFY 2009. Denominator: Total number of counties in Wisconsin.

**Sources of Information:** WI MEDS Electronic Screen warehouse.

**Special Issues:** The MH/SA Functional Screen is a standardized web-based screening tool that is used to determine level of need for consumers. It began in 2005 and is currently being spread across the state to ensure equal access to care and appropriate assignments to treatment.

**Significance:** The implementation of the MH/SA Functional Screen is a major initiative in Wisconsin to increase the consistency with which level of need is determined in Wisconsin’s major mental health programs. The use of the web-based screen to collect standardized data and calculate automated level of need determinations helps increase the consistency of assessments and the appropriateness of placements.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin has developed a system of functional screens with both demographic and functional level data on the population in Wisconsin needing long term care or needing services and supports beyond clinic services. These screens are web based, can populate information automatically between the different types of screen (children to adult, long term care to mental health and substance abuse,) and can be automatically transferred from one county to another to assure the consistency of determination of need criteria across geographic boundaries. Screeners are required to be certified and there are web-based courses for each screen attached to the UW Madison Wisconsin teaching web site. Continuing education credits are earned for becoming a certified screener and the Division of Mental Health and Substance Abuse Services has a quality plan that assures the quality of screens being applied to the population looking for services and supports beyond mental health outpatient care.

The screen can give DMHSAS real time data on the population in Wisconsin being screened, it contains diagnoses, levels of functioning for all activities of daily living and assesses comprehensive levels of risk as well as identifying trauma. Local agencies can use it for a number of activities: data driven quality improvement efforts; assessing case load mix; assessing service gaps at the local level; and assessing progress in improvement of functional levels of consumers at both the individual and aggregate levels.

It is the intent of DMHSAS to promote the use of the screen state wide by 2010 for all certified psycho-social programs beyond outpatient services. This will ensure continuity of care for consumers within Wisconsin as they move from county to county, real time data for both the state and local agency and create the ability for the state to set functional

outcomes for agencies who manage these programs. The screen is already mandatory for two major programs and the plan is to promote it for CSP programs the next two years.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:** Target achieved.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Resources for consumer support programs.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	847,000	902,000	991,629	991,629	109.93
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** At least maintain resources to consumer-run programs and services and to family support services.

**Target:** Maintain funding for consumer and family programs and services in FFY 2009.

**Population:** Consumers and family members.

**Criterion:** 5:Management Systems

**Indicator:** Percentage change in the amount of funds allocated to family support and consumer-run programs, services and training in FFY 2009.

**Measure:** Amount of MHBG funding allocated to family support and consumer-run programs in FFY 2009.

**Sources of Information:** MHBG funding allocation data.

**Special Issues:** Wisconsin's goal is to maintain or increase funding levels for consumer and family support services in FFY 2009. Given the context of the Management Systems criterion, this indicator is designed to monitor Wisconsin's ongoing resource commitment for consumer support and consumer-run programs.

**Significance:** Active consumer and family involvement is essential to a redesigned mental health care system.

**Activities and strategies/ changes/ innovative or exemplary model:** The plan for FFY 2008 included an additional \$28,000 from the Systems Change budget area for family support services while also maintaining the current funding of \$874,000 for consumer self-help and support services, for a total of \$902,000 being spent on consumer and peer support. An increase to \$991,629 is proposed for FFY 2009 to provide services in the same areas of adult consumer support, adult and family consumer support, and child and family support.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	12,066	12,080	12,201	12,032	98.61
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase the number of children who have access to services in the public mental health system. (National Outcome Measure)

**Target:** Increase the number of children served through the public mental health system in FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Number of children ages 4-17 receiving mental health services in FFY 2009.

**Measure:** Number of children ages 4-17 receiving services through the public mental health system in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** The data to monitor Wisconsin's progress on access to care for children will be taken directly from Basic Data Table 2A that the state is required to report in the annual MHBG Implementation Report.

**Significance:** Children's mental health services are expanding in Wisconsin, but increased access to a comprehensive public mental health system is still an important issue for children and their families.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2009, Wisconsin will use a number of different methods to increase the number of children with access to services in the public mental health system. First, the Comprehensive Community Services (CCS) benefit provides an expanded choice of MA-funded mental health services. Wisconsin continues to increase the number of certified CCS programs in the state on an annual basis by providing \$100,000 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four were added in FFY 2008. The CCS benefit is for both adults and children. Some of the state's CST programs are beginning to integrate the CCS benefit within their programs and Wisconsin have educated additional counties to do the same in FFY 2009-2010. Increasing the number of counties that provide CCS benefits will bring services to more children in new areas of the state. Twenty-nine counties have certified CCS programs as of November 2009.

Wisconsin has been developing collaborative systems of care since 1989. The original initiatives, Integrated Services Projects (ISPs), focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities. ISPs receive \$80,000 annually in Mental Health Block Grant (MHBG) Funds.

The expansion of children's mental health services has been a long-standing goal of the Wisconsin Council on Mental Health (WCMH), parents, providers, advocates, and the Department. Through increased funding from the Mental Health Block Grant, the Coordinated Services Teams (CST) initiative began in December 2002 with collaboration between multiple systems: mental health, child welfare, substance abuse, juvenile justice, and public instruction. Initiative funding is made available through a blend of Mental Health Block Grant and Substance Abuse Block Grant funds, state general purpose revenue, and child welfare dollars. This funding is being used to bring about a change in the way that supports and services are delivered to families who require substance abuse, mental health, and/or child welfare services. In addition to blended funding, the initiative reduces out-of-home placements, treats the family as a unit, develops strong cross-system partnerships,

and supports family participation in the decision-making process.

Implementing tele-health also provides a vehicle for expanded mental health services in rural parts of the state where these services are currently unavailable. Tele-health services expanded in FFY 2008 to three additional counties. In 2009, 15 new providers, including six new county providers and 26 new programs, including 15 county programs were certified. The Division of Mental Health and Substance Abuse (DMHSAS) has contracted with UW-Madison to bring its clinical resources to rural Wisconsin via audio and video communication technologies (tele-health). A three-pronged approach will be used: (a) a tele-health clinics will bring UW-Madison expertise to the counties with greatest need to provide direct clinical case consultation and treatment, (b) the quality of the existing workforce will be enhanced through quarterly distance education initiatives focusing on evidence-based treatments, and (c) the Mental Health and Education Resource Center (MHERC) on the UW Madison campus will provide point-of-need high-quality information to mental health professionals and consumers through a "warm line" staffed by a highly trained and experienced medical/mental health librarian.

The Division of Mental Health and Substance Abuse Services also began providing funding to counties in FFY 2007 to implement mental health screening practices within their child welfare systems. Funding in FFY 2008 also was provided for this project to increase the referral of children from the child welfare system to assessments for identification of needed mental health treatment.

**Target Achieved or Not Achieved/If Not, Explain Why:** The 2009 was not achieved, but was very close (98.61 percent). Wisconsin will continue the strategies listed above to improve access to the public mental health system for children in the state.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	8.01	9.92	10.80	13.87	77.87
Numerator	162	212	--	269	--
Denominator	2,023	2,138	--	1,939	--

Table Descriptors:

**Goal:** Decrease the rate of readmission to psychiatric hospitals within 30 days. (National Outcome Measure)

**Target:** Decrease the rate of readmission to psychiatric hospitals within 30 days by 0.5 percent annually in FFY 2009.

**Population:** Children and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of children discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 30 days.

**Measure:** Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 30 days.  
Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** The data to monitor readmissions to psychiatric hospitals for children will be taken directly from Developmental Data Table 21, which states are required to report in the annual MHBG Implementation Report.

Wisconsin has been working on improving the completeness and quality of the HSRS data used to inform this indicator and increased reporting has occurred as a result. In FFY 2007, Milwaukee County and other increased their reporting resulting in a large increase in the number of inpatient admissions and a change in the readmission rate. The data after FFY 2006 now provides more accurate rates to informal mental health system planning.

**Significance:** Community-based treatment is at the core of the service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of the wraparound approach in the community.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of one-half of one percent in the readmission rate over the FFY 2010 period. There are a number of programs that will likely have an impact on this indicator:

- The CCS benefit will expand the availability of outpatient MA-funded mental health services. In FFY 2009, there are 29 certified CCS programs in Wisconsin.
- Continued funding of crisis programs through the five multi-county initiatives will also serve to reduce the number of inpatient placements including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years which began in FFY 2006.
- Increasing the number of counties that are operating a CST will reduce the number of out-of-home placements by expanding the availability of wraparound services. An additional seven counties and tribes began CST programs in FFY 2008. Additionally, six counties and two tribes began CST programs in FFY 2009.
- Funding was provided to five pilot county child welfare agencies to implement mental health screening practices to increase the identification and referral of children to mental health treatment. This initiative will be continued in 2010.

When children are discharged from psychiatric hospitals, these are the expected increased service options that will be available to them. Becoming engaged with these service/program options after discharge from a psychiatric hospital should reduce the incidence of readmissions.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Target not achieved. The number and cost of care for severely emotionally disturbed children continues to grow in Wisconsin. Residents of Wisconsin also have a higher rate of use of state psychiatric hospitals and community inpatient psychiatric services compared to the national average. At the same time, state and county budgets are shrinking due to reduced revenue. The Governor's Budget includes several measures aimed at reducing institutionalization and expanding community treatment for children with severe emotional disturbance. As of January 2010, Wisconsin counties will be required to contribute to the cost of care for children and elderly patients at state psychiatric hospitals. This change will increase the fiscal responsibility of Wisconsin counties at a time when county administrators are cutting services or raising taxes to offset reduced revenues.

The aim of the Wisconsin Mental Health Collaborative is to reduce unnecessary/inappropriate admissions and readmissions to inpatient facilities among the state's persistent and severely mentally ill. Experts in quality improvement from the University of Wisconsin (NIATx) are partnering with the State Division of Mental Health and Substance Abuse Services to identify, recruit, and provide technical support to five to eight Wisconsin counties. Key stakeholders from the State Division of Mental Health and Substance Abuse Services, county governments, and appropriate representatives of state and community-based psychiatric facilities will also be invited to participate in the collaborative.

The University of Wisconsin (NIATx) will draw on its experience in designing change strategies and building learning collaboratives in behavioral health to change practices in counties committed to reducing unnecessary/inappropriate inpatient admissions and readmissions. Lessons learned from the collaborative initiative will be used to help reduce readmissions statewide.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	19.97	21.47	23.10	31.30	73.80
Numerator	404	459	--	607	--
Denominator	2,023	2,138	--	1,939	--

Table Descriptors:

**Goal:** Decrease the rate of readmission to psychiatric hospitals within 180 days. (National Outcome Measure)

**Target:** Decrease the rate of readmission to psychiatric hospitals within 180 days by at least 0.5 percent annually for FFY 2009.

**Population:** Children and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of children discharged from all state and county psychiatric hospitals in CY 2009 who are readmitted within 180 days.

**Measure:** Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2009 who are readmitted within 180 days.  
Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2009.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** The data to monitor readmissions to psychiatric hospitals for children will be taken directly from Developmental Data Table 21, which we are required to report in the annual Implementation Report.

Wisconsin has been working on improving the completeness and quality of the HSRS data used to inform this indicator and increased reporting has occurred as a result. In FFY 2007, Milwaukee County and others increased their reporting resulting in a large increase in the number of inpatient admissions and a change in the readmission rate. The data after FFY 2006 now provides more accurate rates to inform mental health system planning.

**Significance:** Community-based treatment is at the core of the service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of the wraparound approach in the community.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of one-half of one percent in the readmission rate over the FFY 2010 period. There are a number of programs that will likely have an impact on this indicator:

- The CCS benefit will expand the availability of outpatient MA-funded mental health services. In FFY 2009, there are 29 certified CCS programs in Wisconsin.
- Continued funding of crisis programs through the five multi-county initiatives will also serve to reduce the number of inpatient placements including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years which began in FFY 2006.
- Increasing the number of counties that are operating a CST will reduce the number of out-of-home placements by expanding the availability of wraparound services. An additional seven counties and tribes began CST programs in FFY 2008. Additionally, six counties and two tribes began CST programs in FFY 2009.
- Funding was provided to five pilot county child welfare agencies to implement mental

health screening practices to increase the identification and referral of children to mental health treatment. This initiative will be continued in 2010.

When children are discharged from psychiatric hospitals, these are the expected increased service options that will be available to them. Becoming engaged with these service/program options after discharge from a psychiatric hospital should reduce the incidence of readmissions.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Target not achieved. The number and cost of care for severely emotionally disturbed children continues to grow in Wisconsin. Residents of Wisconsin also have a higher rate of use of state psychiatric hospitals and community inpatient psychiatric services compared to the national average. At the same time, state and county budgets are shrinking due to reduced revenue. The Governor's Budget includes several measures aimed at reducing institutionalization and expanding community treatment for children with severe emotional disturbance. As of January 2010, Wisconsin counties will be required to contribute to the cost of care for children and elderly patients at state psychiatric hospitals. This change will increase the fiscal responsibility of Wisconsin counties at a time when county administrators are cutting services or raising taxes to offset reduced revenues.

The aim of the Wisconsin Mental Health Collaborative is to reduce unnecessary/inappropriate admissions and readmissions to inpatient facilities among the state's persistent and severely mentally ill. Experts in quality improvement from the University of Wisconsin (NIATx) are partnering with the State Division of Mental Health and Substance Abuse Services to identify, recruit, and provide technical support to five to eight Wisconsin counties. Key stakeholders from the State Division of Mental Health and Substance Abuse Services, county governments, and appropriate representatives of state and community-based psychiatric facilities will also be invited to participate in the collaborative.

The University of Wisconsin (NIATx) will draw on its experience in designing change strategies and building learning collaboratives in behavioral health to change practices in counties committed to reducing unnecessary/inappropriate inpatient admissions and readmissions. Lessons learned from the collaborative initiative will be used to help reduce readmissions statewide.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1	1	1	1	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of evidence-based practices for children. (National Outcome Measure)

**Target:** To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources in FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of evidence-based practices used for children in the state in FFY 2009.

**Measure:** Number of evidence-based practices used for children in the state in FFY 2009.

**Sources of Information:** EBP Survey.

**Special Issues:** The first challenge for Wisconsin is collecting reliable statewide data on the use of evidence-based practices. We will use funding from the Data Infrastructure Grant (DIG) to develop a survey that will be sent to all county providers.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin's Collaborative Systems of Care go by many names such as CST, Wraparound, ISP, and Children Come First. These are all approaches that respond to individuals and families with multiple, often serious needs in the least-restrictive setting possible. They are not specific programs or services, rather, processes based on family and community values that are unconditional in their commitment to creatively address needs. Creative services are developed by a client-centered team that support normalized, community-based options. Each team develops an individualized plan, which incorporates strengths of the participant and team to address needs. Participants are equal partners and have ultimate ownership of the plan. The "wraparound approach" is listed in SAMHSA's Matrix of Children's Evidence-Based Interventions.

The Wraparound Milwaukee program is nationally recognized for its implementation of the Wraparound approach. WAM has data showing significant efficacy for their enrollees and has published their evaluation results in journals as well as presented at numerous conferences across the nation. In 2006, Wraparound Milwaukee served 979 children and youth with serious emotional disorder and a high proportion of those enrollees were involved in the Juvenile Justice System. Wraparound Milwaukee served approximately 1,050 children in 2008 and 1,200 children in 2009.

In FFY 2009, Wisconsin is assessing the options for implementing additional evidence-based practices for children's services, including significant background research on the needs of the state and the elements of the evidence-based practices. Once the assessment of the use of evidence-based practices is complete for the state, decisions can be made about which evidence-based practices can be used as resources throughout the state. The state will help facilitate the dissemination of training resources across counties for the implementation of evidence-based practices for children.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** To facilitate the use of Therapeutic Foster Care as an evidence-based practice for children.
- Target:** To facilitate the use of Therapeutic Foster Care for children by funding their implementation and disseminating training resources in FFY 2009.
- Population:** Children with SED and their families.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children receiving Therapeutic Foster Care in the state in FFY 2009.
- Measure:** Number of children receiving Therapeutic Foster Care in the state in FFY 2009.
- Sources of Information:** No current source of data exists.
- Special Issues:** Wisconsin is currently facilitating the implementation of EBPs through the provision of grants to five counties. A statewide system of data collection for consumers served specifically with EBPs is not available, but Wisconsin is currently working to integrate this function into existing data systems.
- Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties chose Illness Management and Recovery (IMR) for adults. None of the current five counties chose to implement Therapeutic Foster Care for children at this time. The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers, including Therapeutic Foster Care. Although these grants have focused on adults to date, the BPTR will encourage counties to consider using EBPs for their youth consumers as well.

In addition, the DMHSAS formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the DMHSAS. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine whether some local providers are already using Therapeutic Foster Care and thus the reporting for this EBP could change in the future.

**Target Achieved or Not Achieved/If Not, Explain Why:** N/A



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of Multi-Systemic Therapy as an evidence-based practice for children.  
**Target:** To facilitate the use of Multi-Systemic Therapy for children by funding their implementation and disseminating training resources in FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
 3:Children's Services

**Indicator:** Number of children receiving Multi-Systemic Therapy in the state in FFY 2009.

**Measure:** Number of children receiving Multi-Systemic Therapy in the state in FFY 2009.

**Sources of Information:** No current data source exists.

**Special Issues:** Wisconsin is currently facilitating the implementation of EBPs through the provision of grants to five counties. A statewide system of data collection for consumers served specifically with EBPs is not available, but Wisconsin is currently working to integrate this function into existing data systems.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers’ needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties are chose Illness Management and Recovery (IMR) for adults. None of the current five counties chose to implement Mult-systemic Therapy for children at this time. The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers, including Multi-Systemic Therapy. Although these grants have focused on adults to date, the BPTR will encourage counties to consider using EBPs for their youth consumers as well.

In addition, the DMHSAS formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the DMHSAS. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin’s efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has Community Support Programs based on the ACT model established in almost all 72 counties and many of them are providing some type of supported housing, but the degree to which is being implemented with complete fidelity to the Supported Housing model is unknown. Wisconsin has children’s mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group’s efforts will help determine whether some local providers are already using Supported Housing and

thus the reporting for this EBP could change in the future.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:** N/A

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of Family Functional Therapy as an evidence-based practice for children.

**Target:** To facilitate the use of Family Functional Therapy for children by funding their implementation and disseminating training resources in FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of children receiving Family Functional Therapy in the state in FFY 2009.

**Measure:** Number of children receiving Family Functional Therapy in the state in FFY 2009.

**Sources of Information:** No current data source exists.

**Special Issues:** Wisconsin is currently facilitating the implementation of EBPs through the provision of grants to five counties. A statewide system of data collection for consumers served specifically with EBPs is not available, but Wisconsin is currently working to integrate this function into existing data systems.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** In FFY 2007, Wisconsin began using the MHBG to fund specific efforts by counties to implement the CMHS-recommended EBPs for which implementation toolkits are available. Counties were asked to focus on implementing one EBP and were given the option to choose which one they thought would best meet their consumers' needs. Three counties chose Integrated Dual Disorder Treatment (IDDT) and two counties are chose Illness Management and Recovery (IMR) for adults. None of the current five counties chose to implement Family Functional Therapy for children at this time. The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers, including Family Functional Therapy. Although these grants have focused on adults to date, the BPTR will encourage counties to consider using EBPs for their youth consumers as well.

In addition, the DMHSAS formed an EBP work group in August 2007 to formally define EBPs and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the DMHSAS. A variety of definitions of EBPs and EBP categorizations exist in the field, including distinguishing EBPs from Best Practices and Promising Practices. The work group will focus part of its efforts on examining these definitions and determining which one fits best with Wisconsin's efforts. This process of distinguishing EBPs will help Wisconsin clarify how EBPs are chosen for implementation and how federal reporting is completed. For example, Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBPs or best practices. The EBP work group's efforts will help determine whether some local providers are already using Family Functional Therapy and thus the reporting for this EBP could change in the future.

**Target Achieved or Not Achieved/If Not, Explain Why:** N/A



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	42.47	45.27	47	N/A	N/A
Numerator	141	153	--	N/A	--
Denominator	332	338	--	N/A	--

Table Descriptors:

**Goal:** Improve client perception of care. (National Outcome Measure)

**Target:** To increase the perception of care of parents/guardians annually by two percent annually.

**Population:** Children with SED.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of parents or guardians of child consumers responding to the satisfaction survey with a "positive" response about the outcome of their treatment as measured by the Outcomes scale on the survey.

**Measure:** Numerator: The number of parents or guardians with a "positive" response about the outcome of their child's treatment as measured by the Outcomes scale in FFY 2009.  
Denominator: The total number of parents or guardians responding to the youth survey in FFY 2008.

**Sources of Information:** Mental Health Statistical Improvement Program's Youth Services Survey.

**Special Issues:** A sample of parents/guardians of child mental health consumers is surveyed throughout the state. The sampling must be representative of the state and must be monitored. If the sample becomes unbalanced based on important demographic or geographic characteristics, a modified sampling approach will be used to correct the balance.

**Significance:** Without understanding the consumer's and/or guardian's perspective on a child's service experience, a crucial piece of data is missing in understanding the effectiveness of mental health services.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin collects consumer satisfaction data using the Mental Health Statistical Improvement Program's (MHSIP) adult and youth consumer satisfaction surveys. For assessing satisfaction with children's services, the Bureau uses the MHSIP Youth Services Survey that is administered to a parent or guardian of the youth. Funding from the DIG for FFY 2005-2010 has been budgeted to fund the administration of the satisfaction surveys.

In FFY 2009, Wisconsin will analyze the data from the MHSIP to attempt to ascertain which services have the lowest scores for satisfaction, and the reasons for the low satisfaction with these services. In FFY 2010, Wisconsin will begin planning for the implementation of strategies to increase satisfaction with these low-scoring services.

It is the intent of DMHSAS to move towards an outcome-based, consumer-focused system where quality improvement is built into the programs at the local level. To that end, we have developed mechanisms to collect outcome data and quality indicators and intend to change the way in which we evaluate the success of services and supports provided. We have developed the MH/AODA Functional Screen that local agencies can use to develop indicators from so that quality improvement efforts can be data driven. We have also started using the Recovery-Oriented System Indicators (ROSI) survey to assess the degree to which mental health service systems have implemented Recovery principles. This QI effort has begun in five counties and will be offered to an expanding number of counties in the coming year to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance. In addition, the five counties should be able to use the ROSI results to help explain consumer satisfaction levels in their programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Unknown--The 2009 MHSIP survey data will not be available until April of 2010. The data will be submitted in an amendment to the Implementation report.



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	37.66	31.60	35	N/A	N/A
Numerator	90	73	--	N/A	--
Denominator	239	231	--	N/A	--

Table Descriptors:

**Goal:** Increase school attendance. (National Outcome Measure)

**Target:** To increase the percentage of children whose school attendance has increased since receiving services by three percent annually.

**Population:** Children with SED.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of children with SED whose school attendance has increased in FFY 2009 since starting mental health services.

**Measure:** Numerator: Number of children 6-18 years old with SED whose school attendance has increased in FFY 2009 since starting mental health services.  
Denominator: Number of children 6-18 years old with SED whose parent/ guardian reported their school attendance on the MHSIP youth satisfaction survey in FFY 2009.

**Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) youth satisfaction survey.

**Special Issues:** The MHSIP youth satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about school attendance involvement to the survey as a method of collecting consistent data across states on this topic. Parents/guardians respond to the survey about their child's experience with mental health services. Wisconsin's MHSIP survey is a random sample of all youth mental health consumers with SED that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be representative for all youth with SED who are served in the public mental health system in the state. For this indicator, survey respondents describe if their child's school attendance has been "greater", "about the same", or "less" since they started to receive mental health services. Parents/guardians who responded that their child's school attendance had been "greater" are included in the percentage value in the indicator table.

**Significance:** Children's level of school attendance is an important indicator of his/her interest in education and ability to stay engaged with positive school activities.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual increase of three percent in the increased school attendance rate over the FFY 2009 period. While Wisconsin does not have a program initiative specifically targeted at increasing school attendance, there are a number of programs that will likely have an impact on this indicator:

There are 48 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Wraparound Milwaukee is a model for children's community mental health initiatives in Wisconsin. One of the goals of the project is to divert children with serious emotional disturbance from the juvenile justice system. Wraparound Milwaukee serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

Other wraparound and integrated services projects across the state including Integrated Services Programs (ISP), Coordinated Services Teams (CST), and Comprehensive Community Services (CCS) programs also provide supports and services to enable children

with SED to avoid entering the juvenile justice system or other restrictive environments.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2007, Wisconsin added six counties and two tribes to its CST initiative: Juneau, Ashland, Burnett, Menominee, Monroe and Price Counties; Lac Courte Oreilles and Red Cliff Tribes. In FFY 2008, four counties were added including: Vernon, Buffalo, Sawyer, and Wood. In 2009, two tribes and four counties were added: Bad River and Lac du Flambeau Tribes; Clark, Green, Kewaunee, and Oconto Counties. There are currently 37 counties and four tribes developing and/or sustaining CST initiatives. Additionally, Grant County has been developing CST without a full implementation grant, but they do receive some limited training and technical assistance funding.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

To improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSRS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Unknown--The 2009 MHSIP survey data will not be available until April of 2010. The data will be submitted in an amendment to the Implementation report.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	61.33	61.67	59	N/A	N/A
Numerator	46	37	--	N/A	--
Denominator	75	60	--	N/A	--

Table Descriptors:

**Goal:** Decrease juvenile justice involvement for mental health consumers. (National Outcome Measure)

**Target:** To decrease the percentage of youth mental health consumers involved with the juvenile justice system by three percent annually.

**Population:** Children with SED.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of youth with SED with no arrest in FFY 2009 after being arrested in FFY 2008.

**Measure:** Numerator: Number of youth 6-18 years old with SED who had no arrests in FFY 2009 after being arrested in FFY 2008.  
Denominator: Number of youth 6-18 years old with SED who were arrested in FFY 2008.

**Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) youth satisfaction survey – Caregiver Report.

**Special Issues:** The MHSIP youth satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about juvenile justice involvement to the survey as a method of collecting consistent data across states on this topic. Parents/guardians respond to the survey about their child's experience with mental health services. Wisconsin's MHSIP survey is a random sample of all youth mental health consumers with SED that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be representative for all youth with SED who are served in the public mental health system in the state. For this indicator, parents/guardians describe if their child was arrested in either FFY 2008 or FFY 2009. The indicator focuses on children arrested in FFY 2008 to see if they were able to avoid being arrested again in FFY 2009.

**Significance:** Involvement with the juvenile justice system is sometimes associated with mental health disorders. While youth are receiving mental health services, it is expected their involvement with the juvenile justice system would decrease compared to their involvement with the system in the past.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of three percent in the juvenile justice system recidivism rate over the FFY 2009 period. While Wisconsin does not have a program initiative specifically targeted at reducing juvenile justice recidivism, there are a number of programs that will likely have an impact on this indicator:

There are 48 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Wraparound Milwaukee is a model for children's community mental health initiatives in Wisconsin. One of the goals of the project is to divert children with serious emotional disturbance from the juvenile justice system. Wraparound Milwaukee serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

Other wraparound and integrated services projects across the state including Integrated Services Programs (ISP), Coordinated Services Teams (CST), and Comprehensive Community Services (CCS) programs also provide supports and services to enable children

with SED to avoid entering the juvenile justice system or other restrictive environments.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2007, Wisconsin added six counties and two tribes to its CST initiative: Juneau, Ashland, Burnett, Menominee, Monroe and Price Counties; Lac Courte Oreilles and Red Cliff Tribes. In FFY 2008, four counties were added including: Vernon, Buffalo, Sawyer, and Wood. In 2009, two tribes and four counties were added: Bad River and Lac du Flambeau Tribes; Clark, Green, Kewaunee, and Oconto Counties. There are currently 37 counties and four tribes developing and/or sustaining CST initiatives. Additionally, Grant County has been developing CST without a full implementation grant, but they do receive some limited training and technical assistance funding.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

To improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSRS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

Unknown--The 2009 MHSIP survey data will not be available until April of 2010. The data will be submitted in an amendment to the Implementation report.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	53.57	53.79	53	52	101.92
Numerator	1,874	1,907	--	1,790	--
Denominator	3,498	3,545	--	3,442	--

Table Descriptors:

**Goal:** Increase stability in housing. (National Outcome Measure)

**Target:** To decrease the percentage of youth consumers in unstable housing by one percent annually.

**Population:** Children with SED.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The percentage of children with SED in an unstable living situation in FFY 2009.

**Measure:** Numerator: Number of children 0-17 years old with SED in an unstable living situation in FFY 2009.  
Denominator: Number of children 0-17 years old with SED receiving services through the public mental health system in FFY 2009 for whom living situation data has been reported.

**Sources of Information:** Human Services Reporting System (HSRS) data.

**Special Issues:** The specifications for reporting the living situation data for this indicator are taken from the federally-required Uniform Reporting System (URS) Table 15 on living situation to ensure consistent reporting in the State Plan and the Implementation Report. Although "unstable" living situations are not specifically defined in federal guidance, this indicator defines it as including residential settings, institutional settings, correctional settings, and homeless status.

**Significance:** Although residential and inpatient treatment settings, for example, may be necessary for some children temporarily, the lack of an ongoing stable living situation is a barrier to a child and family's ability to cope with the child's mental health disorder.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual decrease of one percent in unstable housing situations over the FFY 2008 period. While Wisconsin does not have a program initiative specifically targeted at improving stability in housing, there are a number of programs that will likely have an impact on this indicator:

There are 48 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Wraparound Milwaukee is a model for children's community mental health initiatives in Wisconsin. One of the goals of the project is to divert children with serious emotional disturbance from the juvenile justice system. Wraparound Milwaukee serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

Other wraparound and integrated services projects across the state including Integrated Services Programs (ISP), Coordinated Services Teams (CST), and Comprehensive Community Services (CCS) programs also provide supports and services to enable children with SED to avoid entering the juvenile justice system or other restrictive environments.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2006 starting July 1, Brown County received funding to create a CST program. In FFY 2007, Wisconsin added one more CST in Dodge County. There are currently 42 counties involved with CST programs. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. In 2009, six counties and two tribes will be added: Sawyer, Wood,

Bad River Tribe, Lac du Flambeau Tribe, Clark, Green, Oconto, and Kewaunee.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

Additionally, to improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSRS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	76.65	78.76	80	N/A	N/A
Numerator	256	267	--	N/A	--
Denominator	334	339	--	N/A	--

Table Descriptors:

**Goal:** Increase social supports/social connectedness. (National Outcome Measure)

**Target:** To increase the percentage of parents/guardians of youth mental health consumers with social supports by one percent annually.

**Population:** Children with SED.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The number of parents/guardians of children with SED who have social supports in their community in FFY 2009.

**Measure:** Numerator: Number of parents/guardians of children 6-18 years old with SED who agree they have social supports to rely on in their community in FFY 2009.  
Denominator: Number of parents/guardians of children 6-18 years old with SED responding about the degree of social supports they have in their community on the MHSIP youth satisfaction survey in FFY 2009.

**Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) youth satisfaction survey.

**Special Issues:** The MHSIP youth satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about social supports to the survey as a method of collecting consistent data across states on this topic. Parents/guardians respond to the survey about their child's experience with mental health services. Wisconsin's MHSIP survey is a random sample of all youth mental health consumers with SED that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be representative for all youth with SED who are served in the public mental health system in the state. Survey respondents report how much they agree or disagree on a 5-point scale for four survey questions to generate an overall scale score for the availability of social supports to them.

**Significance:** A parent's/guardian's ability to help their child successfully complete treatment and maintain that success after completing services can be enhanced by having social supports within friends, family, and/or community.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual increase of one percent in the rate of social connectedness for children with SED over the FFY 2008 period. While Wisconsin does not have a program initiative specifically targeted at increasing social connectedness, there are a number of programs that will likely have an impact on this indicator:

There are 48 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Wraparound Milwaukee is a model for children's community mental health initiatives in Wisconsin. One of the goals of the project is to divert children with serious emotional disturbance from the juvenile justice system. Wraparound Milwaukee serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

Other wraparound and integrated services projects across the state including Integrated Services Programs (ISP), Coordinated Services Teams (CST), and Comprehensive Community Services (CCS) programs also provide supports and services to enable children with SED to avoid entering the juvenile justice system or other restrictive environments.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2007, Wisconsin added six counties and two tribes to its CST initiative: Juneau, Ashland, Burnett, Menominee, Monroe and Price Counties; Lac Courte Oreilles and Red Cliff Tribes. In FFY 2008, four counties were added including: Vernon, Buffalo, Sawyer, and Wood. In 2009, two tribes and four counties were added: Bad River and Lac du Flambeau Tribes; Clark, Green, Kewaunee, and Oconto Counties. There are currently 37 counties and four tribes developing and/or sustaining CST initiatives. Additionally, Grant County has been developing CST without a full implementation grant, but they do receive some limited training and technical assistance funding.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

To improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSRS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

Unknown--The 2009 MHSIP survey data will not be available until April of 2010. The data will be submitted in an amendment to the Implementation report.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	44.88	47.63	51	N/A	N/A
Numerator	149	161	--	N/A	--
Denominator	332	338	--	N/A	--

Table Descriptors:

- Goal:** Improved level of functioning. (National Outcome Measure)
- Target:** To increase the percentage of youth consumers with improved functioning by three percent annually.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** The percentage of youth with SED whose parent/guardian report improved functioning as a result of their mental health services in FFY 2009.
- Measure:** Numerator: Number of children 6-18 years old with SED whose parent/guardian report generally improved functioning as a result of mental health services received through the public mental health system in FFY 2009.  
Denominator: Number of children 6-18 years old with SED whose parent/ guardian responded about their general ability to function on the MHSIP youth satisfaction survey in FFY 2009.
- Sources of Information:** Mental Health Statistical Improvement Program's (MHSIP) youth satisfaction survey.
- Special Issues:** The MHSIP youth satisfaction survey is recommended by the federal Center for Mental Health Services (CMHS) to be used by all states. In addition to the standard satisfaction questions, CMHS has added questions about general functioning to the survey as a method of collecting consistent data across states on this topic. Parents/guardians respond to the survey about their child's experience with mental health services. Wisconsin's MHSIP survey is a random sample of all youth mental health consumers with SED that is representative of the state. Thus, the numerator and denominator for this indicator are small, but the percentage value is meant to be representative for all youth with SED who are served in the public mental health system in the state. Parents/guardians report how much they agree or disagree on a 5-point scale with five survey questions to generate an overall scale score for how their child's ability to function has changed as a direct result of the mental health services they've received in the last year. The survey questions address areas of general functioning such as "My child is better able to do things he or she wants to do" and "My child is better at handling daily life."
- Significance:** One of the primary goals of mental health services is to improve the consumer's ability to cope with their mental health disorder and function within his/her different domains of life.
- Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin projects an annual increase of three percent in the level of functioning rate over the FFY 2009 period. While Wisconsin does not have a program initiative specifically targeted at level of functioning, there are a number of programs that will likely have an impact on this indicator:

There are 48 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Wraparound Milwaukee is a model for children's community mental health initiatives in Wisconsin. One of the goals of the project is to divert children with serious emotional disturbance from the juvenile justice system. Wraparound Milwaukee serves families living in Milwaukee County who have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

Other wraparound and integrated services projects across the state including Integrated Services Programs (ISP), Coordinated Services Teams (CST), and Comprehensive Community Services (CCS) programs also provide supports and services to enable children with SED to avoid entering the juvenile justice system or other restrictive environments.

Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2007, Wisconsin added six counties and two tribes to its CST initiative: Juneau, Ashland, Burnett, Menominee, Monroe and Price Counties; Lac Courte Oreilles and Red Cliff Tribes. In FFY 2008, four counties were added including: Vernon, Buffalo, Sawyer, and Wood. In 2009, two tribes and four counties were added: Bad River and Lac du Flambeau Tribes; Clark, Green, Kewaunee, and Oconto Counties. There are currently 37 counties and four tribes developing and/or sustaining CST initiatives. Additionally, Grant County has been developing CST without a full implementation grant, but they do receive some limited training and technical assistance funding.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

To improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSRS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.

**Target Achieved or  
Not Achieved/If  
Not, Explain Why:**

Unknown--The 2009 MHSIP survey data will not be available until April of 2010. The data will be submitted in an amendment to the Implementation report.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Improve access to telehealth consultation in rural areas.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	11.11	11.11	12	18.06	162.55
Numerator	8	8	--	13	--
Denominator	72	72	--	72	--

Table Descriptors:

**Goal:** Improve access to tele-health consultation in rural areas.

**Target:** Increase the number of certified tele-health systems in rural counties by three annually for FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** Increase the number of certified tele-health systems in rural counties by three annually for FFY 2009.

**Measure:** The number of rural counties with certified tele-health systems in place to serve children in FFY 2009.

**Sources of Information:** Certification data from the state.

**Special Issues:** Tele-health began as a new initiative in Wisconsin in 2005. Counties, regions, or individual providers could join the initiative as participants who provide tele-health. Each entity must be certified to provide and operate the proper telecommunication equipment for consumers. The certification process will take time.

**Significance:** A majority of counties in Wisconsin can be classified as rural. Access to psychiatric services is a gap in Wisconsin's mental health system.

The above indicator addresses Goal 6, Recommendation 6.1 of the President's Freedom Commission on Mental Health:  
 Goal 6--Technology is used to access mental health care and information.  
 Recommendation 6.1--Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

**Activities and strategies/ changes/ innovative or exemplary model:** Wisconsin secured approval for payment under Medicaid for mental health services delivered using tele-health technology in September 2004. Making the services reimbursable through Medicaid allows more children to take advantage of the services provide an incentive to providers to apply for certification. The first three sites were approved in FFY 2005, which included the Marshfield Clinic in Wood County and two of its satellite clinics in Chippewa and Eau Claire Counties. Eau Claire County, however, is classified as an urban county using the definition described earlier in this section, so it is not included in the performance indicator table above. Although additional tele-health programs become certified every year, the lack of funding for acquiring tele-health equipment is still a barrier for some providers. To address this, the Division of Health Care Access and Accountability authorized a payment of \$20 per tele-health visit for the services of the mental health or substance abuse professional providing the consultation.

In FFY 2008, Wisconsin two rural counties became tele-health certified. In 2009, 14 new providers, including six new county providers and 26 new programs, including 15 county programs were added.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Number of Children Receiving Evidence-based Practices

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	2,876	2,371	2,450	2,571	104.94
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To facilitate the use of evidence-based practices for children. (National Outcome Measure)

**Target:** To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources in FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Number of children receiving evidence-based practices in the state in FFY 2009.

**Measure:** Number of children receiving evidence-based practices in the state in FFY 2009.

**Sources of Information:** EBP Survey.

**Special Issues:** The first challenge for Wisconsin is collecting reliable statewide data on the use of evidence-based practices. Wisconsin will use funding from the DIG to develop a survey that will be sent to all county providers. The data included for this indicator is the number of children being served with a wraparound approach in ISPs, CSTs, Wraparound Milwaukee, and Dane County Children Come First.

**Significance:** The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

**Activities and strategies/ changes/ innovative or exemplary model:** Number of children served through wraparound initiatives in years 2007-2009, reflects the number of children served through Wraparound Milwaukee, Dane County Children Come First, CSTs and ISPs during that year.

Wisconsin plans to improve its data on the use of evidence-based practices for other initiatives across the state. Reports on the use of evidence-based practices and medications should come from providers. One of the data collection methods being considered by Wisconsin is a survey administered to key provider staff in each county. These data on the use of evidence-based treatments could be used not only to complete Uniform Reporting System Data Tables 16-17, but also to create an evidence-based practice resource directory for the state.

In FFY 2009-2010, Wisconsin is assessing the options for implementing additional evidence-based practices for children's services, including significant background research on the needs of the state and the elements of the evidence-based practices. Once the assessment of the use of evidence-based practices is complete for the state, decisions can be made about which agencies using evidence-based practices can be used as resources throughout the state. The state will help facilitate the dissemination of training and resources across counties for the implementation of evidence-based practices for children.

The state will research and implement a new evidence-based practice in FFY 2010. The DMHSAS will fund an expert in the evidence based practice to come to Wisconsin and assist DMHSAS staff and local providers. DMHSAS staff will become the ongoing technical assistance providers. The first local providers to be involved will be part of a program to help spread the evidence-based practice to other counties.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** System organization training.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	65.28	75	81.94	81.94	100
Numerator	47	54	--	59	--
Denominator	72	72	--	72	--

Table Descriptors:

**Goal:** Increase the number of counties with children’s service staff trained in organizing collaborative service delivery systems within the children’s wraparound programs.

**Target:** Annually increase by three percent the number of counties with children’s service staff trained in organizing collaborative service delivery systems within the wraparound programs for FFY 2009.

**Population:** Children with SED and their families.

**Criterion:** 5:Management Systems

**Indicator:** Percent of counties with mental health and other children’s service agency staff trained in organizing wraparound programs annually in FFY 2009.

**Measure:** Numerator: Number of counties with mental health and other children’s service agency staff trained in organizing wraparound programs in FFY 2009.  
Denominator: Number of counties in Wisconsin in FFY 2008.

**Sources of Information:** ISP/CST training visit reports.

**Special Issues:** Wisconsin provides initial system organization training for new wraparound programs, but does not track the number of staff trained. In addition, a train-the-trainer model is in effect in which county staff at the initial training provide subsequent training to the rest of their staff. Since it is difficult to track the number of staff trained, the number of counties receiving initial training are used.

**Significance:** One of the primary focal points of wraparound programs is the systems change approach used to organize multiple child-serving agencies into a collaborative service system. Because this is a new approach for many children’s service agencies, staff training is essential at the beginning of the implementation phase to gain staff buy-in to the process. With its emphasis on the family being a part of all treatment decisions, wraparound programs are in accordance with NFC Goal 2.

With its emphasis on the family being a part of all treatment decisions, wraparound programs address Goal 2, Recommendation 2.2 of the President's Freedom Commission on Mental Health:  
Goal 2--Mental health care is consumer and family driven.  
Recommendation 2.2--Involve consumers and families fully in orienting the mental health system toward recovery.

**Activities and strategies/ changes/ innovative or exemplary model:** Achievement of the targets for this performance indicator will be dependent on Wisconsin's ability to increase children's mental health programming.

Wisconsin’s past and ongoing plans for the expansion of children’s wraparound programs include the establishment of new Coordinated Service Team (CST) programs. The CST’s follow the system of care model by involving partners from multiple child-serving agencies on the child’s treatment planning team. The CST model also uses the wraparound approach to service delivery incorporating the necessary family and community supports to help the child and family. In FFY 2006 and 2007 respectively, Wisconsin added Brown and Dodge Counties as additional CSTs. The CST programs are funded for limited terms ranging from 3-5 years. Wisconsin continues to work to expand the number of counties and tribes annually that have a CST and has a goal of eventually establishing CST programs for children and families in all counties and tribes. In FFY 2006 starting July 1, Brown County received funding to create a CST program. In FFY 2007, Wisconsin added one more CST in

Dodge County. There are currently 42 counties involved with CST programs. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. In 2009, six counties and two tribes will be added: Sawyer, Wood, Bad River Tribe, Lac du Flambeau Tribe, Clark, Green, Oconto, and Kewaunee.

Milwaukee, Dane, Marathon, Lincoln, and Langlade Counties operate similar programs that were funded by federal system of care grants or Medicaid managed care. Forest, Vilas, and Oneida Counties also were trained in operating wraparound programs through a federal grant, but the program is no longer fully functional.

An additional program that is a Medicaid psycho-social benefit that serves individuals across the lifespan is the Comprehensive Community Services (CCS) program. As of December 2009, 29 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) State staff will continue to provide training and technical assistance to these counties, as well as provide assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs both a full-time staff person and a part-time individual contractor to provide training and technical assistance for the certification approval process.

In recent years, four to five counties were certified annually to operate a CCS program. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$100,000 in MHBG funds to developing CCS or CSP programs.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

Upload Planning Council Letter for the Implementation Report

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.