Wisconsin

UNIFORM APPLICATION
FY 2010 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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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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STATE NAME: Wisconsin
DUNS #: 36448835

I. AGENCY TO RECEIVE GRANT
AGENCY: Department of Health Services
ORGANIZATIONAL UNIT: Division of Mental Health and Substance Abuse Services
STREET ADDRESS: 1 West Wilson Street
CITY: Madison STATE: WI ZIP: 53717-7851
TELEPHONE: 608-266-2754 FAX: 608-267-9392

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT
NAME: Linda McCart TITLE: Section Chief
AGENCY: Department of Health Services
ORGANIZATIONAL UNIT: Office of Policy Initiatives and Budget
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TELEPHONE: 608-266-9296 FAX: 608-267-0358

III. STATE FISCAL YEAR
FROM: 10/01/2009 TO: 09/30/2010

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
NAME: Peg Algar TITLE: Mental Health Block Grant Planner
AGENCY: Department of Health Services
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CITY: Madison STATE: WI ZIP: 53707-7851
TELEPHONE: 608-266-2754 FAX: 608-267-9392 EMAIL: margaret.algar@wisconsin.gov
Wisconsin

Executive Summary

Please respond by writing an Executive Summary of your current year's application.
Wisconsin’s Community Mental Health Block Grant Plan for FFY 2010-2011
Executive Summary

Background

The federal Department of Health and Human Services, through the Center for Mental Health Services, of the Substance Abuse and Mental Health Services Administration, awards Community Mental Health Block Grants (MHBG) to states to establish or expand an organized community-based system for providing mental health services to adults with serious mental illnesses and children with serious emotional disturbances. In order for the state to receive a MHBG award, it must:

- Submit an application that describes how the state will meet the required federal criteria,
- Provide an overview of the state’s mental health system,
- Identify the state system’s strengths and weaknesses,
- Identify unmet service needs, and
- Identify the state’s plan to address those needs.

The Department of Health Services, Division of Mental Health and Substance Abuse Services (DMHSAS) is Wisconsin’s single state authority for mental health and substance abuse services. In this role, DMHSAS assumes the responsibility to submit the Mental Health Block Grant Plan for the state. This document contains a summary of two key parts of the MHBG—the Adult’s Plan and the Children’s Plan. It outlines the state’s current activities and goals, targets, action plans and funding proposal for the 2010-2011 MHBG period. The federal government also requires that the state address a number of national outcome measures and objectives to improve those measures in the plan. The full Draft 2010-2011 Mental Health Block Grant Adult and Children’s Plans and the Executive Summary can be found at the Wisconsin Mental Health Council’s website at: www.mhc.state.wi.us

Adult and Children’s Plan Description of State Service System

The Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) administers a wide range of services to clients in the community and at state institutions, establishes regulations for treatment providers, supervises and consults with local, state and tribal public and voluntary agencies. The 33.9 FTE’s in the Bureau of Prevention, Treatment and Recovery in DMHSAS carry out the responsibility for oversight of community-based mental health and substance abuse services and the administration of the Mental Health and Substance Abuse Block Grants. The Division collaborates with other state agencies in the promotion and delivery of mental health services, including the DHS Divisions of Long Term Care, Public Health, Quality Assurance, and Health Care Access and Accountability. The other key state agencies that work closely with DMHSAS include the Departments of Public Instruction, Children and Families, Commerce, Corrections, and Regulation and Licensing.

Key areas of leadership of the DMHSAS across service systems and agencies include:

- Promotion of Positive Behavior Supports to reduce seclusion and restraint,
- Child Welfare Screening for children’s mental health needs,
- Development of Coordinated Services Teams that serve kids at risk from across service systems,
Wisconsin’s public mental health system is administered through 67 county/regional program boards covering all 72 counties as governed by Chapter 51 of the Wisconsin state statutes. Counties are responsible for prevention services in collaboration with public health, comprehensive diagnostic and evaluation services, inpatient and residential treatment, outpatient care and treatment, partial hospitalization, emergency care, supportive transitional services, staff training on emergency detention procedures, and planning, development and evaluations of programs. They are responsible for authorizing and paying for all individuals in need of treatment without resources to provide for their own care within the limits of available funding.

ADULT PLAN

Adult Service System’s Strengths and Weaknesses

Strengths:
- The Bureau of Prevention, Treatment and Recovery is promoting an integrated view of mental health and substance abuse services.
- The Comprehensive and Community Services (CCS) program is expanding.
- The state's Youth Suicide Prevention initiative is expanding.
- Consumers are securing employment through CCS and Community Support Programs (CSPs).
- Law enforcement personnel in counties are now required by law to include mental health clinicians in all emergency detentions to state mental health institutions.
- The 2009-2011 State Budget has added additional funding for community mental health services.
- Wisconsin has created a mental health data warehouse with merged HSRS and Medicaid data.

Weaknesses:
- There is a need for greater collaboration to serve consumers with multiple needs.
- There is a lack of access to dental services for mental health consumers.
- There is limited access and availability of mental health services, particularly with regard to psychiatric services.
- Stigma affects the public’s perception of the ability of consumers to lead productive lives.
- Homeless adults who have a severe mental illness (SMI) are still underserved in Wisconsin.
- There is a lack of mental health services in Wisconsin jails and prisons.

Unmet Service Need
- Individuals who are homeless and have a mental illness have a critical need to be served.
- There is a shortage of psychiatric providers who will serve publicly funded mental health consumers.
- Wisconsin has high rates of readmission to state psychiatric hospitals compared to other states.
- There is a lack of coordination between the primary care and mental health systems.
- Programs to serve rural individuals with severe mental illness need to be expanded.
Plans to Address Unmet Service Needs

- Wisconsin's priorities for adults in rural areas are the continual expansion of CSP, CCS and tele-health into rural counties.
- The mental health data warehouse will merge data from counties and Medicaid to improve the quality of data utilized to analyze trends.
- The CCS benefit is being expanded to serve more mental health consumers across the state.
- Evidence-based practices in mental health service delivery are being utilized to improve the quality of services.
- The development of trauma informed services and systems is being promoted across the state.
- System transformation through the promotion of recovery-focused services and involvement of consumers in training and peer support is a priority for the Department.
- Providing mental health services to people who are homeless and have a mental illness is a priority for Wisconsin.

Adult Plan Performance Goals, and Objectives:

Criterion I: Comprehensive Community-Based Mental Health Services—Indicators

Goal 1: Decrease the rate of readmission to psychiatric hospitals within 30 days by one percent annually.

Goal 2: Decrease the rate of readmission to psychiatric hospital within 180 days by one percent annually.

Goal 3: To facilitate the use of evidence-based practices for adults by funding their implementation, and disseminating training resources in FFY 2010, as measured by the number of evidence-based practices used by adults in the state.

Goal 4: To facilitate the use of evidence-based practices for adults by funding their implementation, and disseminating training resources in FFY 2010, as measured by the number of adults receiving evidence-based practices in the state.

Goal 5: Improve client perception of care as measured by percentage of adult consumers with a positive response about the outcome of their treatment.

Goal 6: Implement new CCS programs to increase funding for an expanded array of services in an additional three percent of counties annually.

Goal 7: Increase the percentage of consumers with new or continued employment by one percent annually.

Goal 8: To decrease the percentage of adult mental health consumers involved with the criminal justice system by three percent annually.

Goal 9: To increase the percentage of mental health consumers with social supports by two percent annually.
Goal 10: To increase the percentage of consumers with improved functioning by two percent annually.

Goal 11: To increase the use of IDDT within Community Support Programs by two percent as an evidence-based practice for adults by funding their implementation and disseminating training resources.

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

Goal 1: To increase the number of adults who have access to services in the public mental health system by one percent annually.

Goal 2: To increase the number of consumers served in CCS by 10 percent annually.

Goal 3: To increase access to, and appropriateness of mental health services, by expanding the use of the Mental Health and AODA Functional Screen that will result in an increase in the number of counties using the functional screen by five percent annually.

Goal 4: To increase access to, and appropriateness of mental health services, by expanding the use of the Mental Health and AODA Functional Screen that will result in an increase in the number of consumers screened using the functional screen by five percent annually.

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

Goal 1: To increase access to mental health services for adults with a serious mental illness in rural areas by increasing by two percent the number of rural counties with a CSP.

Goal 2: To increase the number of adults with a serious mental illness who are homeless that receive mental health services by five percent annually.

**Criterion 5: Management Systems.**

Goal 1: Maintain resources to consumer-run programs and services and to family support services.

**CHILDREN’S PLAN**

**Children’s Service System’s Strengths and Weaknesses**

Strengths:
- Wisconsin’s goals for children’s mental health services include expanding Coordinated Services Teams and a wraparound system of care approach to service delivery.
- The state and counties have a commitment to expanding mental health services to meet consumer needs through programs such as CCS and CST.
- The child welfare system partnerships with wraparound system of care development.
- Wisconsin has passed a law requiring that law enforcement include mental health clinicians in all emergency detentions to State Mental Health Institutions.
- Medicaid covers a broad range of services for mental health consumers.
Wisconsin has created a mental health data warehouse with merged HSRS and Medicaid data.
Wisconsin is working to improve reporting on evidence-based practices.

Weaknesses:
- There is a need for greater collaboration to serve consumers with multiple needs.
- Services for children with significant emotional problems, but who are not involved in two or more systems are lacking.
- There is limited access and availability of mental health services, particularly with regard to access to child and adolescent psychiatric services.
- There is a lack of mental health services for children and parents in the child welfare system.
- There is a shortage of Medicaid dental providers that will serve children with mental health needs.
- There is a lack of mental health and substance abuse parity in Wisconsin.
- The HSRS data system and the capacity of the county and state to aggregate, analyze and interpret meaningful data is limited, which makes it difficult for the state to make data-informed decisions.

Unmet Service Needs

- There is a lack of mental health and substance abuse parity in the Wisconsin.
- There is a shortage of publicly funded child and adolescent psychiatrists and psychologists who will serve children with mental health problems.
- There are not adequate services for children and parents with mental health and trauma issues in the child welfare system.
- There is a need for transitional services for youth aging out of the children’s mental health system.
- There are access issues for children’s mental health services.
- There is a shortage of dental services for children under Medicaid.

Plans to Address Unmet Service Needs

- Wisconsin is promoting the use of mental health consultation for infants and young children as well as promote the use of a specialized diagnostic classification system for infants and young children.
- Wisconsin is working on increasing the number of Medicaid funded dental providers that will serve children with SED.
- Wisconsin is working on improving access for children's mental health services by promoting workforce development.
- The Department of Health Services is promoting the use of positive behavior supports to reduce the use of seclusion and restraint in children’s services across the state.
- Start up funding is continuing to support the development of CCS and Coordinated Service Teams to expand services for youth.
- Wisconsin is working toward better coordination of the children's welfare system with the mental health system of care.
- The state is working on improving transitional services for youth aging out of children’s mental health system.
Wisconsin is working toward increasing the use of evidence-based practices in mental health service delivery to improve the quality of services for children.

The state is promoting screening of children and their parents in the child welfare system for mental health and trauma issues.

DHS is partnering with the Department of Public Instruction on youth suicide prevention activities.

The development of trauma informed systems of care is being promoted throughout the state.

Children’s Plan Performance—Goals and Objectives:

Criterion I: Comprehensive Community-Based Mental Health Services—Indicators

Goal 1: To annually increase by two the number of counties with initiatives using the wraparound model for children’s services.

Goal 2: To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources in FFY 2010, as measured by the number of evidence-based practices used by children in the state.

Goal 3: To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources in FFY 2010, as measured by the number of children receiving evidence-based practices in the state.

Goal 4: Improve the perception of care of parents/guardians as measured by a two percentage increase in parents/guardians with a positive response about the outcome of their child’s treatment.

Criterion 2: Mental Health System Data Epidemiology

Goal 1: To increase by one percent the number of children served through the public mental health system annually.

Criterion 3: Children’s Services

Goal 1: Decrease the rate of readmission to psychiatric hospitals within 30 days by at least one percent a year.

Goal 2: Decrease the rate of readmission to psychiatric hospitals within 180 days by at least one percent a year.

Goal 3: Increase the percentage of children whose school attendance has improved since receiving services by three percent annually.

Goal 4: Decrease juvenile justice involvement for youth mental health consumers who recidivate by three annually.

Goal 5: Decrease the percentage of youth consumers in unstable housing by one percent annually.
Goal 6: Increase the percentage of parents/guardians of youth mental health consumers with social supports by one percent annually.

Goal 7: Increase the percentage of youth consumers with improved functioning by three percent annually.

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

Goal 1: Increase the number of certified tele-health systems in rural counties to provide mental health services by three annually.

**Criterion 5: Management Systems.**

Goal 1: Annually increase the percentage of counties with children’s service staff trained in organizing collaborative service delivery systems within the wraparound programs by three percent.

**Expenditure Plan for Mental Health Block Grant Funds for FFY 2010**

At the time of the writing of this application, Wisconsin had not yet been notified by CMHS of its grant award for FFY 2010. The expenditure plan below for FFY 2010-2011 is based on the FFY 2009 award amount.

**Expenditure Plan for Block Grant Funds for FFY 2010**

The Mental Health Block Grant application for FFY 2010 is due to Center for Mental Health Services (CMHS) on September 1, 2009. Although the federal 2010 Budget has not yet been passed by Congress, CMHS has instructed the Division of Mental Health and Substance Abuse Services to assume the same level of funding in FFY 2010, as Wisconsin received in FFY 2009, $7,349,062.

**Proposed FFY 2010 MHBG Budget**

1) **County Formula Allocation (Statutory Cap of $2,513,400) - $2,513,400**

This allocation is designated to county mental health agencies to fund programs for persons with serious mental illness. The DHS determines each county agency's MHBG allocation using its standard Community Aids formula. This formula considers each county agency's Medicaid caseload, per capita income, and urban/rural designation. Each agency will use the funds for one or more of the following eight priority areas:

- Certified CSP and/or CCS program development and service delivery
- Supported housing program development and service delivery
- Initiatives to divert persons from jails to mental health services
- Development and expansion of mobile crisis intervention programs
- Consumer peer support and self-help activities
- Coordinated, comprehensive services for children with SED
- Development of strategies and services for persons with co-occurring MH/SA disorders
- Mental health outcome data system improvement
2) **Children’s Initiatives - ISP and CST** *(ISP Capped by Statute at $1,306,700, but not CST) - $1,826,500*

The ISP initiative is designed to develop coordinated systems of care for children and adolescents with SED and their families requiring support from multiple community-based agencies. State awards give the county projects the capacity to provide the flexibility needed by both children/adolescents and their families. The CST initiative places an even heavier emphasis on collaboration across child-serving systems. The focus is on creating a “systems change” plan for the county or tribe to establish strength-based systems of care that supports children and adolescents and their families who require substance abuse, mental health, juvenile justice, and/or child welfare services.

3) **Family/Consumer Self-Help & Peer-to-Peer Support** *(By Statute, must allocate no less than $874,000) - $991,629*

Wisconsin funds a variety of consumer self-help and peer support programs including programs that work with adult consumers, child consumers, and families of consumers.

4) **Transformation Activities** *(No Statute) - $886,033*

Per federal focus, Wisconsin will continue to use a portion of the block grant to promote system transformation. Activities include working with state partners, counties, tribes, consumers and advocacy groups to focus on transformation of the county and tribal service systems through start-up grants for CCS/CSP programs and to increase use of evidence-based practices such as Supported Employment. Workforce Development grants will promote solutions for workforce shortages for psychiatric services for children and elders. Workforce Technical Assistance will focus on reducing use of seclusion and restraint and the related need to promote trauma informed care. Tribal State Collaborative funding supports a grant that provides technical assistance and strategic planning support to all tribes to improve each systems delivery of integrated treatment for co-occurring mental health and substance use disorders.

**Detailed Budget Breakout**

- County QI-Continuity of Care: $69,702
- CCS Development/Start-Up: $100,000
- CCS Technical Assistance: $40,240
- Child Welfare Screening: $60,000
- Homeless Access & Outreach to Benefits: $74,000
- Supported Employment: $98,000
- Tribal Best Practices in Co-Occurring Disorder: $100,000
- Workforce Dev. & Psych Consultation: $205,164
- Provider TA to Reduce Seclusion & Restraint/Promote EBPs: $52,927
- Promote Trauma Informed System: $86,000

5) **Systems Change** *(By Statute, at least 10% must be for children) - $222,000*

The Systems Change funds will focus heavily on implementing systems change in the areas of improving the current system’s focus on recovery, as well as providing resources for prevention and early intervention and consumer reimbursement as outlined in statutory intent.

**Detailed Budget Breakout**
Consumer/Family Stipends for Participation $25,000
Recovery Coordinator $82,000
Prevention/Early Intervention $95,000
Youth Suicide Prevention $20,000

6) **Training (Statutory Cap of $182,000) - $177,000**
Training funds will be contracted to improve provider knowledge and skills in mental health standards, best practice and emergency crisis services for statewide system delivery for consumers of all ages. These funds support the DMHSAS conferences, training for children’s services, statewide teleconferences on clinical topics, and training for schools on promoting positive behavior supports.

**Detailed Budget Breakout**
- Statewide Teleconferences $87,042
- Annual Conference $10,000
- Geriatric Psychiatry Training $5,000
- Children's Program & Crisis Intervention Training $32,000
- Training for Schools - Positive Behavior Supports $22,958
- Elderly Initiative $20,000

7) **Wisconsin Protection and Advocacy (Statutory Cap of $75,000) - $75,000**
Disability Rights Wisconsin is the designated agency within the state to provide protection and advocacy for persons with mental illness.

8) **State Operation Costs - $657,500**
These funds cover the costs of the staffing for the BPTR, Mental Health Council expenses, accounting, mental health HSRS data expenses, National Outcome Measures reporting and indirect costs of administering the grant.

**Total = $7,349,062**
Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
FUNDING AGREEMENTS

FISCAL YEAR 2010

I hereby certify that _________________________________________ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:
Subject to Section 1916, the State\(^1\) will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912
(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:
(a)(1)(C) In the case for a grant for fiscal year 2010, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

---

\(^1\) The term State shall hereafter be understood to include Territories.
(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:
The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
    (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
    (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:
(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:
(a) The State agrees that it will not expend the grant:
(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:
The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:
(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section.

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.
CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee’s policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central
point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.
5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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### DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
<th>2. Status of Federal Action</th>
<th>3. Report Type:</th>
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<td>a. contract</td>
<td>a. bid/offer/application</td>
<td>a. initial filing</td>
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<td>b. grant</td>
<td>b. initial award</td>
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<td>c. cooperative agreement</td>
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<td>e. loan guarantee</td>
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<td>c. post-award</td>
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<tr>
<th>4. Name and Address of Reporting Entity:</th>
<th>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</th>
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<tbody>
<tr>
<td>Prime Subawardee</td>
<td>Tier ______, if known:</td>
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<td>Congress, if known:</td>
<td>Congressional District, if known:</td>
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| 6. Federal Department/Agency:            | 7. Federal Program Name/Description: |

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<th>7. Federal Program Name/Description:</th>
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<td>CFDA Number, if applicable: _____________</td>
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<th>8. Federal Action Number, if known:</th>
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| 10. a. Name and Address of Lobbying Entity | b. Individuals Performing Services (including address if different from No. 10a.) |
| (if individual, last name, first name, MI): | (last name, first name, MI):         |

| 11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. |

Signature: ____________________________

Print Name: ____________________________

Title: ____________________________

Telephone No.: ______________________ Date: ______________________

Authorized for Local Reproduction

Standard Form - LLL (Rev. 7-97)
INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., “RFP-DE-90-001.”

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.
As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Wisconsin

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.
Section 1 - Federal Funding Agreements, Certifications and Assurances

Directions: Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan in this section.

Comments from the July 15, 2009 Public Hearing on the 2010 MHBG Plan

A hearing for the public to comment on Wisconsin's 2010 Mental Health Block Grant (MHBG) Plan was held from 10:15 am until 1:30 pm on July 15, 2009, in Madison, Wisconsin. The MHBG Plan was posted on the Wisconsin Mental Health Council web page for the public to access and review a week before the hearing. The Plan was also sent out as an e-mail attachment to mental health consumer and advocacy groups. Mental health consumers, advocates, policy makers and private citizens were encouraged to attend the public hearing and provide feedback on the Plan.

The Bureau of Prevention Treatment and Recovery staff also met separately with the Mental Health Council's (MHC) Children's and Adult MHBG Plan Review Sub-Committees during the week of June 22, 2009 to discuss their edits to the Plan. (They were given two weeks to review the documents prior to the meetings.) The MHC Sub-Committee edits were compiled and presented to the full Council at the beginning of the public hearing, along with responses from the Bureau to questions from sub-committee members. Their edits were then incorporated in the MHBG Plan.

The following comments were made regarding the MHBG Plan during the public hearing:

Jean DeJong--Consumer/Advocate

Ms. DeJong identified herself as an older adult with a mental illness and a state advocate for older individuals with mental illness. She stated that programs for older adults who have mental illness are underfunded and that the elderly population is increasing and will continue to increase as the baby-boom generation ages.

Ms. DeJong asserted that often providers assume that older adults need a nursing home level of care to obtain mental health services. Instead, many older individuals can be treated successfully in the community with increased socialization and supports. There is an extraordinary rate of dementia in older adults in Wisconsin and across the country. Ms. DeJong suggested that a simple intervention that can address the progression of dementia is socialization and cognitive stimulation.
Ms. DeJong stated that community outreach programs are needed to provide these types of services/supports. For example, Marlene Dressen (an advocate and provider for older adults with mental health issues) teaches wellness concepts to older adults in their homes. Ms. Dressen obtains modest funding and local donations to support her work. She also trains other consumers/volunteers to provide community supports to older adults with mental illness. This is similar to the peer support model utilized with seriously mentally ill adults.

Community outreach is critical, as many older adults do not want to go to an agency or hospital to obtain mental health services. Ms. DeJong stated that older adults are afraid of losing their autonomy and independence. As many of these individuals could do well with supports and services in the community, it is necessary to do outreach and address their issues before they decompensate enough to need institutionalization.

Ms. DeJong stated that the Recovery Implementation Task Force has a sub-committee working on the issue of outreach to older adults in the community with mental health issues. Funding is needed to support these types of initiatives, particularly in rural areas. The outreach programs should focus on wellness education, socialization, and cognitive stimulation. Supporting this type of approach will create a cost savings by diverting older adults with mental illness from hospitalization and placement in nursing homes.

Catherine Swanson-Hayes—Private Citizen
Ms. Swanson-Hayes stated that she spoke on behalf of the Older Adult Mental Health Alliance. She stated that the Community Support Program (CSP) and the Comprehensive Community Services (CCS) program should address older individuals in a coordinated manner. She stated that the Milwaukee and Marathon CSPs that served older adults are no longer in operation and that this population's unique needs are not being specifically addressed through the two programs. Ms. Swanson-Hayes stated that there is a need to address the co-occurring illnesses of older adults including physical illness, mental illness and drug interactions from multiple medications.

Ms. Swanson-Hayes cited stigma and fear of losing control of their lives as a barrier to older adults with mental health issues obtaining the supports and services they need. Therefore community outreach is critical to reach this population and to serve them in the least restrictive environment possible. Ms. Swanson-Hayes stated that many older adults with mental illness do not have the level of physical issues that would qualify them for mental health services through Family Care.

Ms. Swanson-Hayes proposed a plan to create a coalition of community stakeholders to identify and engage older persons in non-threatening and supportive ways. The coalition would develop a plan to educate ageing service providers, general practitioners and other primary care doctors on community outreach to this population. She stated that there already exist some models for an expanded initiative including wellness programs and mobile outreach in Dane County that is funded with county dollars. Additionally, other states such New Hampshire are implementing model programs that could be replicated in this state.

Ms. Swanson-Hayes suggested that access for older adults to community mental health services can be achieved by modifying existing programs to better cover the total lifespan. This would involve additional training for providers on the unique needs of older adults with regard to co-occurring problems, particularly because of multiple medications.
**Michael Bachhuber--Advocate-Consumer**
Mr. Bachhuber stated, in response to the testimony on the need for outreach to older adults, that there is a need for more community outreach to all individuals in the state who have serious emotional disturbances or mental illness. He stated that the 55% of the older adults served through Family Care have secondary diagnoses of mental illness.

Mr. Bachhuber also stated that BPTR has lost the staff person who covered the deaf and hard of hearing population in the state. He states that this is very concerning and that this population is one that is underserved and also requires community outreach.

He also brought up the issue of supportive housing. He stated that it is a good approach, but it is important not to offer it in a large housing facility; an integrated setting is better to normalize the living situation for consumers. Additionally, linking services to housing can be problematic because consumers might feel coerced into treatment in order to retain their housing.

**Sister Ann-Catherine Veierstakler--MHC Member**
Sister Veierstakler stated that it is important to have a nurse and social worker on-site at public housing complexes. She stated that a sense of community is also extremely important for consumers, particularly when they are symptomatic.

**Judy Wilcox--MHC Member**
Ms. Wilcox stated that congregating people with mental illness is not healthy. It is important to have scattered-site housing, or mixed housing with both disabled and non-disabled individuals.
II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:
State FY _____ X _____ Federal FY ______

State Expenditures for Mental Health Services

<table>
<thead>
<tr>
<th>Calculated FY 1994</th>
<th>Actual FY 2008</th>
<th>Estimate/Actual FY 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,122,573</td>
<td>$2,122,311</td>
<td>$2,255,611</td>
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</table>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.
III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principal agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

<table>
<thead>
<tr>
<th></th>
<th>State FY X</th>
<th>Federal FY</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Expenditures for Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual FY 2007</td>
<td>$165,212,074</td>
<td></td>
</tr>
<tr>
<td>Actual FY 2008</td>
<td>$189,678,384</td>
<td></td>
</tr>
<tr>
<td>Actual/Estimate FY 2009</td>
<td>$182,081,299</td>
<td></td>
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</table>
MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.
<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone and Fax</th>
<th>Email (If available)</th>
</tr>
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<tbody>
<tr>
<td>Bachhuber, Michael</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>ILCW-Independent Living Council of Wisconsin</td>
<td>210 W. Washington Ave. Suite 110 Madison, WI,WI 53703 PH:608-444-5520 FAX:</td>
<td><a href="mailto:director@ilcw.org">director@ilcw.org</a></td>
</tr>
<tr>
<td>Baldwin, Jackie</td>
<td>Family Members of Children with SED</td>
<td>P.O. Box 268 St. Germain, WI,WI 54558 PH:715-542-3535 FAX:</td>
<td><a href="mailto:Jackiebaldwin@verizon.net">Jackiebaldwin@verizon.net</a></td>
<td></td>
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<tr>
<td>Boreson, Lynn</td>
<td>State Employees</td>
<td>Education</td>
<td>P.O. Box 7841 Madison, WI,WI 53707-7841 PH:608-266-1218 FAX:</td>
<td><a href="mailto:Lynn.boreson@dpi.state.wi.us">Lynn.boreson@dpi.state.wi.us</a></td>
</tr>
<tr>
<td>Briggs, Corrie</td>
<td>Family Members of adults with SMI</td>
<td></td>
<td>91 Amherst Circle Hudson, WI,WI 54016 PH:715-386-6007 FAX:</td>
<td><a href="mailto:corenb@sbcglobal.net">corenb@sbcglobal.net</a></td>
</tr>
<tr>
<td>Easterday, John</td>
<td>State Employees</td>
<td>Mental Health</td>
<td>1 West Wilson Street Madison, WI,WI 53707 PH:608-267-9391 FAX:</td>
<td><a href="mailto:EasteJT@dhfs.state.wi.us">EasteJT@dhfs.state.wi.us</a></td>
</tr>
<tr>
<td>Eithun-Harsner, Kim</td>
<td>State Employees</td>
<td>Social Services</td>
<td>1 W. Wilson Street Room 650 Madison, WI,WI 53707 PH:608-267-9391 FAX:</td>
<td><a href="mailto:EithuKC@dhfs.state.wi.us">EithuKC@dhfs.state.wi.us</a></td>
</tr>
<tr>
<td>Name</td>
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<td>Agency or Organization Represented</td>
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<td>Email (If available)</td>
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<tr>
<td>Hands, Donald</td>
<td>State Employees</td>
<td>Criminal Justice</td>
<td>3099 E. Washington Avenue Madison, WI, WI 53704 PH:608-240-5112 FAX:</td>
<td><a href="mailto:Donald.Hands@Wisconsin.gov">Donald.Hands@Wisconsin.gov</a></td>
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<tr>
<td>Mirkin, Leslie</td>
<td>State Employees</td>
<td>Vocational Rehabilitation</td>
<td>4913 Fond du Lac Trail Madison, WI, WI 52370 PH:608-242-4865 FAX:</td>
<td><a href="mailto:Leslie.mirkin@dwd.state.wi.us">Leslie.mirkin@dwd.state.wi.us</a></td>
</tr>
<tr>
<td>Neubauer, Mary</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>4570 S. Nicholson Ave. Apt. 16 Cudahy, WI, WI 53110 PH:414-807-6505 FAX:</td>
<td><a href="mailto:maryneubauer@aol.com">maryneubauer@aol.com</a></td>
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<tr>
<td>Parker, Amy</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>5 Walter Street Madison, WI, WI 53714 PH:920-342-2184 FAX:</td>
<td><a href="mailto:beebuz@sbcglobal.net">beebuz@sbcglobal.net</a></td>
</tr>
<tr>
<td>Quaal, John A.</td>
<td>Family Members of Children with SED</td>
<td></td>
<td>1231 Turnberry Drive Pewaukee, WI, WI 53072 PH:262-695-4051 FAX:</td>
<td><a href="mailto:jquaal@wi.rr.com">jquaal@wi.rr.com</a></td>
</tr>
<tr>
<td>Rasmus, Martha</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>6604 Heidelberg Circle Waterford, WI, WI 553185 PH:262-442-8233 FAX:</td>
<td><a href="mailto:mha@mhamilw.org">mha@mhamilw.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Type of Membership</td>
<td>Agency or Organization Represented</td>
<td>Address, Phone and Fax</td>
<td>Email (If available)</td>
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<tr>
<td>--------------------</td>
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<tr>
<td>Roetter, Kathy</td>
<td>Providers</td>
<td>County</td>
<td>2611 12th Street S., Wisconsin Rapids, WI, WI 54494 PH: 715-421-8821 FAX:</td>
<td><a href="mailto:kroetter@co.woodwi.us">kroetter@co.woodwi.us</a></td>
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<tr>
<td>Stephens, Joann T.</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>W7897 Eagle Avenue Westfield, WI, WI 53964 PH: 608-296-3373 FAX:</td>
<td><a href="mailto:mnjstephens@maqs.net">mnjstephens@maqs.net</a></td>
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<tr>
<td>Swanson, Katharine</td>
<td>Providers</td>
<td></td>
<td>920 12th Avenue West Ashland, WI, WI 54806 PH: 715-682-9070 FAX:</td>
<td><a href="mailto:swansonK@centurytel.net">swansonK@centurytel.net</a></td>
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<tr>
<td>Veierstahler, Sister Ann Catherine</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>3601 South 41st Street Milwaukee, WI, WI 53221 PH: 414-384-6535 FAX:</td>
<td><a href="mailto:srann@hopetohealing.com">srann@hopetohealing.com</a></td>
</tr>
<tr>
<td>Walker, Benita</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>1325 E. Johnson Street Madison, WI, WI 53703 PH: 608-251-2905 FAX:</td>
<td><a href="mailto:bswalker@execpc.com">bswalker@execpc.com</a></td>
</tr>
<tr>
<td>Wilcox, Judy</td>
<td>Others (not state employees or providers)</td>
<td></td>
<td>202 North Blount Street #22 Madison, WI, WI 53703 PH: 608-255-8913 FAX:</td>
<td><a href="mailto:judywilcox@charter.net">judywilcox@charter.net</a></td>
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<td>Name</td>
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<td>Wrenn, Donna</td>
<td>State Employees</td>
<td>Housing</td>
<td>201 W. Washington Avenue Madison, WI, WI 53703 PH: 608-264-7625 FAX:</td>
<td><a href="mailto:donna.wrenn@wisconsin.gov">donna.wrenn@wisconsin.gov</a></td>
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</tbody>
</table>
### TABLE 2. Planning Council Composition by Type of Member

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL MEMBERSHIP</td>
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<td></td>
</tr>
<tr>
<td>Consumers/Survivors/Ex-patients (C/S/X)</td>
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<td></td>
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<tr>
<td>Family Members of Children with SED</td>
<td>2</td>
<td></td>
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<tr>
<td>Family Members of adults with SMI</td>
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<td></td>
</tr>
<tr>
<td>Vacancies (C/S/X and Family Members)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Others (not state employees or providers)</td>
<td>1</td>
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<tr>
<td><strong>TOTAL C/S/X, Family Members and Others</strong></td>
<td>11</td>
<td><strong>57.89%</strong></td>
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<tr>
<td>State Employees</td>
<td>6</td>
<td></td>
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<tr>
<td>Providers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL State Employees and Providers</strong></td>
<td>8</td>
<td><strong>42.11%</strong></td>
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</table>

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.
Wisconsin

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council’s efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
- the role of the Planning Council in improving mental health services within the State.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State’s transformation activities that are described in Part C, Section II and Section III. </STRONG>
3. PLANNING COUNCIL CHARGE, ROLE AND ACTIVITIES

As described in Article III of the Wisconsin Mental Health Council bylaws, the Council charge, role and activities include the following:

Section 1. Authority

The Council is created in the Department of Health Services (DHS) pursuant to section 15.197(1) Wis. Stats. Its responsibilities are specified under 51.02 Wis. Stats. and 42 U.S.C. Subchapter XVII, Part B, Subpart i.

Section 2. Purpose

The purpose of the Council is to assist the State in the development and implementation of a comprehensive mental health system with a coordinated array of services and other assistance for adults and children with mental illness or who have other mental health problems. The goal is to facilitate recovery through independence, productivity and integration into the community as well as to advocate for and promote wellness, prevention and early intervention.

Section 3. Responsibilities

3.1 The Council shall do all of the following:

a. Advise the DHS, the Legislature and the Governor on the use of State and Federal resources and on the provision and administration of programs for persons who are mentally ill or who have other mental health problems, for groups who are not adequately served by the mental health system, for the prevention of mental health related purposes.

b. Provide recommendations to the DHS on expenditure of federal funds received under the Mental Health Block Grant under 42 United States Code 300x - 300x-9 and participate in developing, monitoring and evaluating the implementation of the Mental Health Block Grant Plan.

c. Review all DHS plans for services affecting persons with mental illness, monitor the implementation of the plans, and provide its recommendations concerning the plans to the Secretary of DHS within such time as the Secretary may require.

d. Serve as an advocate for individuals with severe mental illness, including children with severe emotional disturbance (SED), and other persons with mental health issues.

e. Submit annually, a report on recommended policy changes in the area of mental health to the DHS, the chief clerk of each house of the Legislature [for distribution to the Legislature under Wis. Stats. 13.172(2)], and to the Governor.

f. Per federal requirement, monitor, review and evaluate, not less than once each year, the allocation and adequacy of all mental health services in the State.

g. Meet at least four times annually.
h. Promote the development and administration of a delivery system for community mental health services that is sensitive to the needs of recipients of the services.

3.2 The Council may do all of the following:

a. Report to the public concerning needs of persons with mental illness or other mental health problems and the issues that affect persons of all ages.

b. Report to DHS what resources are necessary for the Council to fulfill its statutory obligations.

c. Form committees for consideration of policies or programs for persons of all ages who have mental illness or other mental health problems.
Wisconsin

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
Section 1 - Description of State Service System

1. Adult and Child Overview of State's Mental Health System

Directions: A brief description of how the public mental health system is currently organized at the State Mental Health Agency's authority in relation to other State agencies.

The State Mental Health Authority in Relation to Other State Agencies

The State Mental Health Authority is in the Division of Mental Health and Substance Abuse Services (DMHSAS) in the Department of Health Services (DHS). DHS is one of the many cabinet level agencies that are a part of the Executive Branch. The Secretaries of each cabinet level agency or department are appointed by and report to the Governor in Wisconsin.

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

- The Division of Public Health (DPH) promotes the health and well being of Wisconsin citizens and visitors through programs which encourage positive and healthful lifestyles and identify preventive and remedial actions to eliminate, correct, and/or alleviate diseases and health hazards. DPH is responsible for providing public health services and environmental and public health regulation.

- The Division of Quality Assurance (DQA) certifies, licenses and surveys approximately 46 kinds of health care and residential programs in the state of Wisconsin. Examples the health care providers certified through DQA are hospitals, nursing facilities, intermediate care facilities for persons with mental retardation, end-stage renal dialysis centers, hospice agencies, and home health agencies.

- The Division of Enterprise Services (DES) provides management support for the department related to fiscal services, information technology and personnel issues.

- The Division of Health Care Access and Accountability (DHCAA) is responsible for administering programs such as Medicaid, BadgerCare, BadgerCare Plus, FoodShare, SeniorCare and disability determination.

- Division of Long Term Care (DLTC) oversees the provision of long-term support options for the elderly and people with disabilities such as the Family Care Program. DLTC also operates the Department's institutions for persons with developmental disabilities.

Other state departments work closely with the State Mental Health Authority on a regular basis including the following:

- The Department of Children and Families (DCF) responsibilities include public child welfare, regulation and licensing of child caring facilities, youth development and a broad range of community programs. It oversees the Wisconsin Temporary Assistance to
Needy Families (TANF) programs, called Wisconsin Works (W2), which is designed to move welfare recipients into the labor force. It also provides the direct administration and operation of Milwaukee County's Child Welfare System.

- The Department of Commerce administers the state’s economic development as well as administers financial assistance for local government and businesses. The agency is also responsible for providing housing assistance to benefit low-income and moderate-income households, as well as administering state and federal funding to combat homelessness. Their responsibilities include the oversight of the Projects for Assistance in Transition from Homelessness (PATH) program. DMHSAS has a formal Memorandum of Understanding with the Department of Commerce about how the departments will work together to improve services for people who are homeless and have a severe mental illness.

- Department of Corrections (DOC). The Department of Corrections administers the state adult prison, probation and parole systems, along with administering the oversight of the local juvenile justice system. The DOC contracts with the DMHSAS to run the state prison inpatient mental health facilities.

- Department of Military Affairs (DMA), Division of Emergency Management. This department has responsibility for developing and implementing the state emergency operations plan; provides assistance to local jurisdictions in the event of a disaster and administers private and federal disaster and emergency relief funds.

- Department of Regulation and Licensing (DRL). The Department of Regulation and Licensing is responsible for credentialing and regulating various professions and occupations in the state. The DRL also investigates and prosecutes complaints against credential holders.

- Department of Veteran’s Affairs (DVA). This department provides educational and economic assistance to eligible veterans. It also operates a variety of facilities, services and supports that provide support for Wisconsin’s veterans who are incapacitated due to age or disability.

- Department of Workforce Development (DWD). This department is responsible for a variety of work-related programs designed to connect people with employment opportunities in Wisconsin. It also is responsible for job centers, job training, placement services as well as employment related services for people with disabilities through their Division of Vocational Rehabilitation.

- Department of Public Instruction (DPI). This department is independent of the Governor, with an elected constitutional officer, the State Superintendent of Public Instruction. DPI provides direction and technical assistance for public elementary and secondary education in Wisconsin. They offer a broad range of programs and professional services to local school administrators and staff, distributes state and federal school aids and works to improve curriculum and school operations, and ensures education for children with disabilities.
Organization of the State Mental Health Authority

The Division of Mental Health and Substance Abuse Services (DMHSAS) is the designated State Mental Health Authority that directs public mental health services in Wisconsin. The Division is comprised of the Division Administrator, John Easterday, the Deputy Administrator, an office associate, three program units, and four direct care facilities. The Bureau of Prevention Treatment and Recovery (BPTR) is one of the three program units and is responsible for activities related to implementation of the MHBG. The BPTR currently consists of three Sections and 33.9 FTEs including the Director and the Director’s Office Associate.

Bureau of Prevention Treatment and Recovery (BPTR)

Mental Health Services and Contracts Section
- The Mental Health Services and Contracts Section is responsible for monitoring the programmatic and administrative guidelines for the provision of mental health outpatient services throughout the state.
- The section plans and monitors the implementation of the MHBG including the creation of the federally-required annual Mental Health Plan and Implementation Reports. Staffing for the Wisconsin Council on Mental Health is provided by this section.
- Some integrated MH/Substance Abuse functions are the responsibility of the Mental Health Services and Contracts Section.
- The section is responsible for mental health and substance abuse programming for the deaf and hard of hearing and Pre Admissions Screening and Resident Review (PASRR).
- The Mental Health Services and Contracts Section monitors CSPs for adults with severe and persistent mental illness reside as well as programs that target housing and staff coordinate with the Department of Commerce on homeless issues.
- Finally, all evaluation functions for mental health and substance abuse reside in this section including the management of the Human Services Reporting System (HSRS), Data Infrastructure Grant (DIG) projects, evaluation design, and data analysis.
- The Mental Health Services and Contracts Section has 6.5 FTEs and a .5 LTE.

Substance Abuse Services Section
- The Substance Abuse Services Section provides a focus for services and programs designed primarily for individuals with substance abuse issues.
- Substance abuse and prevention programs have been consolidated within this section from across the bureau and include oversight of the substance abuse administrative rules, Access to Recovery, methadone programs, the Intoxicated Driver Program (IDP) and the injection drug use program.
- The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is administered from the Substance Abuse Services Section.
- The Substance Abuse Prevention and Treatment State Plan (SAPTBG application) is created and monitored and staff provide general oversight of the implementation of the plan.
- Staffing for the State Council on Alcohol and Other Drug Abuse (SCAODA) is provided from this section.
- Responsibility for substance abuse prevention programming also resides in this Section.
- The Substance Abuse Services Section has 9.0 FTEs.

Integrated Systems Development Section
- The Integrated Systems Development Section has 11.4 FTEs plus one .5 LTE.
- The Children Youth & Families Unit is an integrated unit and has 6 FTEs who work on children's issues with co-occurring disorders, prevention/early intervention, Substance Abuse Child Care Grants (SPIT), Substance Abuse contract administration and SA teleconferences.
- Additionally, the staff in the Division of Long Term Care’s Children Long Term Waiver unit provide support for children in the Children’s Long Term Support SED Waiver.

**Children, Youth, and Families Unit**
- The Children, Youth, and Families Unit addresses the special needs of children and families who have mental health and/or substance abuse disorders.
- One of the primary functions of the Children, Youth, and Families Unit is to address the goals of the Governor’s Kids First Initiative. An example of a program in the unit is Coordinated Service Teams for children that provide a comprehensive systems approach to case management for children that are involved with more than one system of care, but may not meet the definition of severely emotionally disturbed.
- All children’s mental health and substance abuse programs and services are consolidated in this unit. Staff in the Children, Youth and Families unit work to strengthen existing integrated MH/Substance Abuse approaches and implement new integrated approaches where needed.
- The unit has 6 FTEs that provide contract monitoring, technical assistance, training, and programmatic guidance to the Integrated Service Projects, Coordinated Service Teams, and Hospital Diversion programs targeted for children with SED who may also have substance abuse disorders. (Coordinated Service Teams also serve children without SED who are involved in two or more systems.)
- The unit is responsible for the Child Welfare Initiatives, prevention and early intervention programming, and programs to benefit infants such as the Infant Mental Health Initiative.
- Unit staff also assists in monitoring the Comprehensive Community Services (CCS) benefit for children, providing clinical consultation services for individuals with substance abuse and/or severe mental illness, agencies providing services and monitoring child and family advocacy activities.

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

Mendota Mental Health Institute, a psychiatric hospital operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services, specializes in serving patients with complex psychiatric conditions, often combined with certain problem behaviors. Mendota provides a secure setting to meet the legal and behavioral needs of our patients. Mendota also operates outpatient treatment services for individuals in the community.

Winnebago Mental Health Institute is a psychiatric hospital owned and operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. Winnebago specializes in serving children, adolescents and adults with complex psychiatric conditions that are often combined with challenging behaviors. Winnebago provides a secure setting to meet the legal, behavioral, treatment and recovery needs of patients.

**Secure Treatment Facilities**

The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs. A youth’s motivation for positive change is also part of that assessment. Parents or guardians receive program and treatment review reports during a youth’s stay on MJTC.

Sand Ridge Secure Treatment Center offers a range of treatment programs for its patients designed to meet the specific needs of sexually violent persons. The inpatient treatment program consists of several phases and components with a multi-disciplinary approach. It is based on a psycho-social rehab model with an emphasis on cognitive-behavioral and relapse prevention techniques. The length of time in treatment is dependent upon successful program completion as evidenced by the patient's consistent demonstration of mastery of self-management skills.

The Wisconsin Resource Center (WRC) is administered by the Wisconsin Department of Health Services in partnership with the Wisconsin Department of Corrections. WRC is a specialized mental health facility established as a prison under s. 46.056, Wisconsin Statutes. WRC is also identified as a treatment facility for the placement of Sexually Violent Persons (SVPs) detained or admitted pursuant to Chapter 980, Wisconsin Statutes. The facility operates as a secure treatment center and is managed by the Division of Mental Health and Substance Abuse Services. The budgeted capacity of WRC is 404: 344 male inmates transferred from Wisconsin Department of Corrections (DOC) Division of Adult Institution prisons for mental health care and 120 men detained or committed under the SVP program pursuant to Chapter 980 of the Wisconsin Statutes.
Wisconsin

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
Section 1 - Description of State Service System

2. New Developments and Issues

Directions: New developments and issues that affect mental health service delivery in the State, including structural changes such as waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

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

*See Adult Legislative Initiatives and Changes Section for Further Details on the Outpatient Rule Revision.

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 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 contract and require/encourage partnerships between agencies serving adults with disabilities and medical managed care experience, and
- implementing 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: 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.


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.
• Because in many counties it is possible that the same infrastructure supports a number of different populations (individuals with mental health and substance abuse issues, individuals who are developmentally disabled, physically disabled and older adults), the shift of the developmentally disabled, physically disabled and older adult populations to Family Care could have an impact on the infrastructure left to serve the MH and SA populations through the county systems.

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 in December 2009.

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. 54.17 percent of the Wisconsin population will be covered by a Managed Care Organization (MCO). Responses to an Request For Proposals (RFP) from organizations interested in providing Family Care to Milwaukee County residents with disabilities under age 60 or those who are elderly 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

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

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 will extend 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

BadgerCare Plus will provide 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.

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 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.

**Real Choice Systems Change Grants and Money Follows the Person (MFP) Demonstration Grants**

The New Freedom Initiative Real Choice Systems Change Grants were extensions of The New Freedom Initiative; these grants, which are funded by the Centers for Medicare and Medicaid Services (CMS), supported infrastructure changes that will result in effective and enduring improvements in community long-term support systems. The Money Follows the Person (MFP) Demonstration Grants also are funded by CMS and are part of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. They will assist States in their efforts to reduce their reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities. This demonstration grant finances home and community-based Medicaid services for individuals who transition from institutions to the community and supports States in rebalancing their long-term support systems.

In January 2007, Wisconsin was awarded a Money Follows the Person Demonstration grant. Under the demonstration, Wisconsin receives enhanced federal match for participant service costs for the first 12 months a qualified person lives in the community. MFP is operated in conjunction with existing relocation mechanisms for individuals in institutions, this includes the COR waiver. People being enrolled in the waiver program must meet the MFP requirements to also participate in it. The Department will reinvest one-time savings from the MFP Demo into home and community-based long term care services. The Department also received a CMS Aging and Disability Resource Center grant to help develop one-stop shopping centers for seniors and people with disabilities who need long-term care information. The Department’s Quality Close to Home (QCTH) project implemented in 2004 was also funded by a Systems Change Grant from CMS. This project supported the development of a comprehensive quality management system for home and community-based long-term care programs and the results identified areas were consistent approaches could be used to assure that consumers of all programs were receiving acceptable quality of service. The project’s final report on a preliminary design for an integrated quality management system was produced in October 2006.

Wisconsin received two grants from the Centers for Medicare and Medicaid Services; a Real Choice Systems Grant and a New Freedom Initiative Grant. The DMHSAS has identified key nursing facilities that have significant numbers of residents with mental health diagnosis and that have expressed willingness to jointly plan with county staff for community placement. One goal is to ensure that the system incorporates best practice models that include comprehensive, recovery-based assessment and planning. Relocation involvement at the time of facility closure or downsizing is also actively pursued as a time to provide technical assistance regarding community placement options. In January 2007 Wisconsin received approval of its proposal for a Money Follows the Person Demonstration Grant.
Medicaid Preferred Drug List (PDL)

To control costs and provide clinically sound drug therapy for recipients, the Wisconsin Division of Health Care Financing 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. NAMI estimates one in four families nationwide has someone with severe mental illness.

Dr. Ron Diamond, 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. 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 nearly dried up 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 via patient revenues.

**Development of the New Community Support Program Rule**

Work will begin in the fall of 2009 on revision of the Community Support Program Administrative Rule for Wisconsin. The Recovery Implementation Task Force has recommended that the utilization of the SAMHSA ACT toolkit be required of all certified CSPs. This will improve fidelity of Wisconsin CSPs to the ACT evidence-based model.

**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.
Wisconsin

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.
Section 1 - Description of State Service System

3. Legislative Initiatives

Directions: Legislative initiatives and changes, if any.

Mental Health and Substance Abuse Parity

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 vote. A companion bill was introduced in the Assembly late in the session. The bill could not be acted on before the session ended.

Parity has been achieved at the Federal level. It is unclear how this policy will affect Wisconsin.

Informed Consent for Admission of Minors to Inpatient or Outpatient Mental Health Treatment

An additional issue is that currently the mental health laws distinguish between minors under 14 years of age and minors 14 years of age or older with regard to giving informed consent for treatment. No distinction exists between a minor under 14 years of age and a minor 14 years of age or older with regard to treatment for alcoholism or drug abuse. Wisconsin Act 444, was enacted in May of 2006 and eliminated the distinction between these two groups of minors with regard to treatment for severe mental illness under the mental health laws by changing the rights of minors 14 years or older to be the same as those for minors under 14 years of age.

Specifically, this bill eliminates the requirement that a minor 14 years of age or older:

- Provide his or her written informed consent in addition to that of his or her parent or guardian before he or she received outpatient treatment or psychotropic medication and treatment for severe mental illness. A minor’s consent is permitted, but not required;
- To execute the application for voluntary admission to an inpatient facility without the parent or guardian’s consent before the minor may be admitted to the facility for treatment of severe mental illness;
- To be discharged from inpatient treatment for severe mental illness or developmental disability within 48 hours after solely requesting the discharge, except for a minor whose parent or guardian refused to consent to admission or was unable to be found or for
whom there is no parent with legal custody and who was admitted to an inpatient facility after a hearing;

- To be transferred from a juvenile correctional facility to an inpatient facility for treatment for severe mental illness; and
- To have the right to object to access to his or her court or treatment records by his or her parent, guardian, or person in the place of a parent.

An important change between the former statutory language and language in Act 444 is deletion of the word "voluntary" when referring to admission of a minor. This change ensures that all minors being admitted to inpatient treatment have a verified admission petition which is reviewed by the court. A potential problem being encountered with the implementation of the new law is that not all counties or providers may be aware of it and may possibly not be enforcing it. Also, as the process will involve more staff time and paper work, as well as more court reviews, some providers and counties may desire to avoid implementing the new law.

The Federal NICS Improvement ACT (HR 2640)

On January 8, 2008, President Bush signed into law the NICS Improvement ACT (HR 2640), a law that provides $250 million annually to states that implement laws such as AB70. This bipartisan bill, supported by the NRA, provides guidance to participating states on how to provide relevant and accurate records to the FBI. The new law provides an incentive to states to report people who are ineligible to buy guns. It authorized up to $250 million a year for five years for states to help pay the cost of providing the records, and threatens to withhold federal anti-crime funds from states if they fail to act.

Bills AB424/SB216 and AB70/SB44-Wisconsin's Legislation under the Federal NICS Improvement ACT (HR 2640)

In the 2007-2008 Legislative session, Bills AB424 and SB216 were developed to prevent people committed involuntarily for mental health reasons from purchasing a firearm. These bills are in response to the tragic events at Virginia Tech on April 16, 2007, where a gunman killed 32 people and himself.

These bills related to adjudications for involuntary commitment, appointment of a guardian of the person, and protective placement or protective services, background checks for the purchase of handguns, and requiring the exercise of rule-making authority. AB 424 and SB 216 were not passed.

During the 2009-2010 Legislative session, bills AB70 and SB44, which address the same issue and are constructed similar to AB424 and SB216, were developed. The bills were constructed to ensure that Wisconsin does not go beyond what is required by the federal law in any way which might stigmatize or discriminate against persons with mental illness who may be subject to being listed on the NICS. Specifically the bill requires that the state report only that the individual is not eligible to purchase a handgun, but it does not allow information to be shared that would indicate the reason is related to a mental illness. The law requires that the information gathered and reported to the NICS cannot be released elsewhere. And, finally, it requires that when an individual is not longer under involuntary commitment that their name be removed from the NICS. These were modifications to the bills originally introduced last session that advocates requested and received. There was an amendment to AB70 introduced in the Assembly on July 8, 2009.
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. The effective date of the rule is 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](http://www.legis.state.wi.us/rsb/code/dhs/dhs035.pdf)

The Department created ch. DHS 35, rules relating to outpatient mental health clinics, and revised sections DHS 105.13 (2) and 107.22 rules relating to outpatient mental health services and certification of psychotherapy providers under Medical Assistance (MA).

Chapter DHS 35 addresses procedures for certification; required personnel; service requirements; and denial, involuntary termination or suspension of certification for outpatient mental health clinics; clinical supervision, collaboration, and consultation; written authorization of psychotherapy by a physician; initial assessments of clients and development of treatment plans; progress notes; discharge summaries; and record keeping. In addition to these requirements, these rules require clinics to ensure continuity of care for persons with mental disorders or alcohol and drug abuse problems by rendering or arranging for the provision of specified services, including but not limited to, residential facility placement; aftercare for continuing treatment in the community to help the patient maintain and improve adjustment following a period of treatment in a facility; and emergency care. Section DHS 105.22 provides the requirements for MA certification of psychotherapy providers, staffing of outpatient facilities, and MA reimbursement for outpatient psychotherapy services. Section DHS 107.13 (2) details the Medicaid requirements for covered services for outpatient psychotherapy services, prior authorization and other limits and procedures, and non-covered services under MA.

Creating ch. DHS 35 addresses several areas including, allowing clinics to alternatively meet, the standards of one of several national accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); establishing a detailed certification process similar in both organization and content to the certification process set out in rules for other community mental health certified programs, which includes actions taken against certified programs and permits provisional certification pending correction of minor deficiencies; adding a requirement for a criminal records check on prospective new employees; modifying the requirements for professional staffing of a clinic; changing requirements of staff supervision to a quality improvement process; adding training requirements for clinic staff; adding or expanding rule language on admission, assessment, consent for treatment, treatment planning and medications administration; and adding sections on client rights and obtaining information about client satisfaction with treatment.

Wisconsin has Passed a Law Requiring that Law Enforcement Include Mental Health Clinicians in all Emergency Detentions to State Mental Health Institutions

The 2009-2011 biennial budget requires that law enforcement personnel consult with county mental health crisis staff prior to doing an emergency detention. The past language had been crafted in Chapter 51 to that effect, but had not been effective in enforcing this policy statewide. "Best Practices" were developed also several years ago which required mental health/crisis staff to be involved with law enforcement any time that an emergency detention was being considered. In many counties there had been improvement in this area, resulting in a decrease in emergency detentions and hospital admissions. The new budget requires that all counties adopt and enforce this policy.
2007 Wisconsin Act 108 to Remove Barriers to Health Information Exchange

Health information exchange (HIE) is necessary to improve the quality and safety of health care. Variations in health information privacy law create barriers to the development of HIE in Wisconsin. Act 108 is a significant step toward removing these barriers. It provides physicians and patients with additional and more reliable information as they make important decisions about what health care treatment is best and safe for patients. In addition, this Act better aligns Wisconsin law with the federal Health Insurance Portability and Accountability Act (HIPAA) confidentiality and privacy laws.

Extensive dialogue and collaboration with a wide range of stakeholders resulted in passage of Act 108. Specifically, the changes to Wisconsin Statute 51.30 were developed by a workgroup convened by the Department with representation from many key advocacy and provider organizations. Changes to Wisconsin Statute 146, related to general health records, were discussed with many stakeholder groups as well. There were some concerns on the part of consumers regarding how increased availability of mental health information to a wider range of providers might prejudice their treatment. A key compromise between state policy makers and consumers/advocates was the requirement to develop an anti-stigma curriculum for healthcare providers. On December 4, 2007, the eHealth Care Quality and Patient Safety Board reviewed and approved proposed statutory changes. The Assembly and Senate passed legislation in early March 2008. Governor Doyle signed the legislation on March 17, 2008.

Changes to General Health Information Statute--effective April 1, 2008

2007 Wisconsin Act 108 allows re-disclosure of health information in a way that benefits electronic health information exchange while retaining some limitations on re-disclosure to protect confidentiality. Specifically, it:

- Eliminates the requirement to document all disclosures. Health care providers are still required to document the disclosures required to be tracked under federal HIPAA laws, such as disclosures related to child or elder abuse cases or public health reporting and disclosures to law enforcement and coroners.

- Allows health care providers to disclose health information to a patient's family, friend or another person identified by the patient and involved in the patient's care:
  1. If the patient provides informal permission (rather than formal written consent) to do so.
  2. If the patient is not physically available or physically or cognitively able to grant informal permission or able to determine whether disclosing the information is in the best interests of the patient and the patient would otherwise allow such a disclosure.

Changes to General Mental Health Statute--effective October 1, 2008

2007 Wisconsin Act 108 allows for the exchange of information that physicians have expressed a need to receive and also allows for the exchange of information with any health care provider with a need to know by:

- Adding "diagnostic test results" and "symptoms" to the list of elements that may be exchanged without patient written consent.

- Removing the within a "related health care entity" requirement so that important health care information can be exchanged with any health care provider who is
involved with the patient's care and who needs the information to properly treat the patient, regardless of whether the provider is a part of the clinically integrated setting or health plan where the patient originally received.

Written informed consent of the patient is still required to disclose information other than the specific elements permitted for exchange. For example, a patient's written consent is still required to disclose an entire consultation note or discharge summary.
Wisconsin

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
**Section I - Description of State Service System**

**4. Description of the State's Leadership**

**Directions:** A description of how the State mental health agency provides leadership in coordinating mental health services within the system.

**How the State Mental Health Authority Shows Leadership and Coordinates with the Larger Systems**

The DMHSAS is very involved in coordinating across service systems. This leadership role has been fostered over the past four years and continues to the present time. The State Mental Health Authority, Dr. John Easterday, is a member of the Executive Management Team of the Department of Health Services and interacts on a regular basis with his peers that oversee the following program areas: Medicaid, Public Health, Long Term Care, and Quality Assurance. The Executive Team develops and implements a department wide strategic plan that assures that the priorities of the department are well coordinated.

In addition, DMHSAS staff serves in leadership roles in a number of DHS cross-divisional and cross-department efforts geared towards transforming systems to improve services for people with mental health needs. Those efforts include:

- Medicaid’s Pharmacy Prior Authorization Committee and Mental Health Drug Advisors Group. These groups meet on a regular basis to provide input into Medicaid policies regarding the state’s preferred drug list and to improve prescribing practices.
- Departmental Infant Mental Health Leadership Team (IMHLT). This group’s charge is to carry out the Governor’s KidsFirst initiative to assure that children grow up healthy through the provision of appropriate socio-emotional development. The mission of the DHS IMHLT is to integrate infant and early childhood mental health principles and practices across all divisions in DHS as well as other Departments and community organizations. All divisions of the department participate with leadership from the DMHSAS.
- Seclusion and Restraint Workgroup. The DMHSAS is in the lead staff role of this workgroup focused on reducing the use of seclusion and restraint, in particular with programs serving children across the various divisions of DHS and DCF.
- Coordinated Services Team Executive Committee. This team led by the DMHSAS in collaboration with the Department of Children and Families, oversees the development of this initiative to assure a cross system approach to providing services and supports to children and their families using a wrap around approach. This effort focuses on changing local systems to invest in the creation of local collaborative systems of care for children.
- Child Welfare Screening Team. This team includes representatives from DMHSAS, Child Welfare and Medicaid and implemented a pilot program to provide mental health and substance abuse screening for children entering the child welfare system in 10 counties during 2007 and 2008. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, and also on the impact of trauma. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. The new pilot will target five counties in the northeast region of the state.
• Outpatient Mental Health Rule Stakeholder Group. The DMHSAS staff have been involved in re-writing the outpatient mental health rule. They have involved staff from across the state, including private and public providers, consumers, advocates and other state agency staff. The other state agencies involved included the Divisions of Quality Assurance and Health Care Access and Accountability (HCAA) and the Department of Regulation and Licensing. 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. After the rule is published, 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

• Long Term Care Coordination Committees. Staff from the DMHSAS are involved in a number of committees working to coordinate our efforts with the Division of Long Term Care in the areas of: Aging & Disability Resource Centers, Mental Health and AODA Functional Screen, Home and Community Based Waivers, including the development of the new Community Opportunities in Recovery (COR) Waiver to relocate persons in nursing homes who have a severe mental illness. The COR Waiver program enrolled its first recipient in the beginning of 2008.

• SSI Managed Care Implementation. The DMHSAS works with the DHCAA to expand SSI Managed Care programs and to coordinate their services with the county mental health and substance abuse systems. Through the SSI Managed Care initiative many persons with severe mental illness are now receiving their health care services through HMOs.

• BadgerCare Plus Development. The DMHSAS worked with the DHCAA to develop a plan for mental health and substance abuse benefits in the expanded health care coverage for low income children and adults that will be included in the Governor’s Budget proposal for 2008-2009. The expansion of BadgerCare Plus will extend coverage for basic health insurance to a population not served previously, including people with mental health and substance abuse services needs. The U.S. Department of Health and Human Services (DHHS) and the Department have agreed in principle on a demonstration project waiver of federal law and regulation that will allow for the implementation of the BadgerCare Plus Core Plan for Childless Adults. Wisconsin is waiting for the special Terms and Conditions and the Operation Protocol to be sent to the Department. Once those are reviewed and signed by both parties the waiver will be officially approved.

In addition to these committees and workgroups across the Department, the DMHSAS also works collaboratively to jointly fund grants and contracts to achieve common goals, often resulting from the work in these committees or groups, including:

• Coordinated funding from the Mental Health Block Grant (MHBG), child welfare IV – E funding, and the Substance Abuse Block Grant to expand the Coordinated Services Teams in the state;

• Coordinated funding with both MHBG and child welfare funding for the implementation of the Child Welfare Screening Pilots.

• Through the years, the Infant Mental Health Leadership team (comprised of many divisions across DHS) worked together to develop joint goals and to jointly fund the staffing and development of the state’s Infant and Early Childhood Mental Health Plan. The Leadership team has developed a 2008 Annual Report which details all of the Department's activities related to Infant Mental Health and makes policy recommendations for further action by the Leadership team.
DMHSAS staff also provides leadership roles in a number of cross-departmental efforts, including:

- **Human Services Emergency Management.** The DMHSAS has a staff person who serves as one of the lead DHS staff team members to plan for human service population needs in emergencies and who provides staffing support at the state’s Emergency Management center in the event of a local or state disaster or other critical situation.

- **Trauma Summit Work Group.** The DMHSAS provided leadership to jointly plan and hold a statewide summit on trauma. This effort included individuals from across the divisions at DHS as well as other departments, consumers, advocates and local government representatives.

- A trauma coordinator was hired by the University of Wisconsin-Madison, in partnership with DMHSAS in April of 2008. At that time, the Trauma Coordinator started the "Implementation of Trauma-Informed Care Initiative." The purpose of the initiative is to transform mental health and substance abuse services to be trauma-sensitive. The initiative will incorporate 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.

- **Mental Health Criminal Justice Advisory Committees.** DMHSAS staff serve on a number of committees with the Department of Corrections, Office of Justice Assistance, and the Mental Health Council, to coordinate improvements to the provision of mental health services to inmates and those individuals returning to the community.

- Through the years, DHS has developed memorandums of understanding with the Department of Workforce Development (DWD), Division of Vocational Rehabilitation regarding support for employment services for people with mental health needs. The two agencies have promoted the use of Supported Employment as an evidence-based approach to services.

- The Mental Health Transition Advisory Council (MHTAC) has been in existence since 1999. A statewide plan and action steps have been developed and updated to improve the transition of youth with SED to the adult mental health services they may need and the highest level of independent living they are capable of attaining. MHTAC members represent a coalition of parents, several Departments, Divisions, advocacy agencies, and adolescent and adult programs in several counties.

- **Governor’s State Council on Alcohol and Other Drug Abuse.** DMHSAS provides staff to this state council that focuses on prevention and reducing the impact of alcohol and other drugs in the State. One common issue is the need to promote integrated treatment for people with co-occurring mental health and substance abuse disorders is an area shared in common with this group. Members of all the major state agencies are represented.

- **Wisconsin Council on Mental Health.** The DMHSAS provides support to the Governor’s appointed council that serves as the state planning council for the Mental Health Block Grant. Membership includes individuals from other state agencies that are involved and interested in mental health services which are noted in the membership of the Council in that section of the plan.

- A summit meeting on seclusion and restraint practices with children who are receiving services in the community setting in Wisconsin was held in June 2007. The Department
of Health Services is redesigning public policy on the use of seclusion and restraints. Additionally, during 2007, a Seclusion and Restraint Workgroup was convened to analyze current legislation and regulations across DHS Divisions and programs. Sub-committees of the workgroup were formed to study: legislation and regulation; development of a DHS technical assistance and training plan for providers and administrators; data collection; and identification of prohibited practices. The Wisconsin Department of Health Services (DHS) has gone on record regarding the detrimental effects of these coercive activities, convened workgroups to reduce their use, and over the past 15 months has sponsored three training programs for approximately 22 providers and 460 participants that have focused on the goal of reducing seclusion and restraint in community-based programs regulated by DHS and the Department of Children and Families (DCF).

- A Departmental memo was released in January 2009 that prohibited certain practices in the use of emergency seclusion and restraint.

- The Integration of Physical Health, Mental Health, Substance Use, and Addiction is an initiative developed between the Division of Public Health and the Division of Mental Health and Substance Abuse Services. A Joint Integration Statement was developed collaboratively and has been endorsed by all DHS Divisions, the Secretary of the Department and several external partners. The initiative will promote systemic changes needed to improve health outcomes for individuals, children/youth, families, veterans, and communities in Wisconsin. In acknowledging mental health and physical health are interrelated, services may be better integrated to produce more efficacious treatment. These principles address whole health in assessment and treatment. The whole person including their family and community are addressed.

- In order to support the development of a comprehensive system of coordinated care for children with severe disabilities and their families, the Department established the Children Come First Advisory Committee, with representatives of county departments, the Department of Public Instruction, educational agencies, professionals experienced in the provision of service to children with severe disabilities, families with children with severe disabilities, advocates for such families and their children, the subunit of the Department of Workforce Development that administers vocational rehabilitation, the technical college system, health care providers, courts assigned to exercise jurisdiction under Chapters 48 and 938, child welfare officials, and other stakeholders.

In addition to these standing councils, committees and workgroups, the DMHSAS also enters into a variety of contracts, agreements, and memorandums of understanding with other departments:

- The DMHSAS has a formal Memorandum of Understanding with the Department of Commerce (Commerce) about how the departments will work together to improve services for people who are homeless and have a severe mental illness. This effort has included providing funding for efforts to expand the state’s efforts to do assertive outreach to individuals who are homeless and have a severe mental illness.

- The Department of Corrections (DOC) contracts with DMHSAS to run the state prison inpatient mental health facilities.

- DMHSAS works closely with the Department of Public Instruction (DPI) on many common issues including providing a contract with MHBG funding for technical assistance to local school districts on efforts to expand their suicide prevention efforts;
working with DPI to develop curricula for local school districts on mental health and anti-stigma efforts; and establishing a memorandum of understanding regarding the transition of youth with disabilities into the adult system.
Wisconsin

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
Section 1 - Description of State Service System

1. Adult and Child Overview of State's Mental Health System

Directions: A brief description of how the public mental health system is currently organized at the State Mental Health Agency's authority in relation to other State agencies.

The State Mental Health Authority in Relation to Other State Agencies

The State Mental Health Authority is in the Division of Mental Health and Substance Abuse (DMHSAS) Services in the Department of Health Services (DHS). DHS is one of the many cabinet level agencies that are a part of the Executive Branch. The Secretaries of each cabinet level agency or department are appointed by and report to the Governor in Wisconsin.

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

- The Division of Public Health (DPH) promotes the health and well being of Wisconsin citizens and visitors through programs which encourage positive and healthful lifestyles and identify preventive and remedial actions to eliminate, correct, and/or alleviate diseases and health hazards. DPH is responsible for providing public health services and environmental and public health regulation.

- The Division of Quality Assurance (DQA) certifies, licenses and surveys approximately 46 types of health care and residential programs in the state of Wisconsin. Examples the health care providers certified through DQA are hospitals, nursing facilities, intermediate care facilities for persons with mental retardation, end-stage renal dialysis centers, hospice agencies, and home health agencies.

- The Division of Enterprise Services (DES) provides management support for the department related to fiscal services, information technology and personnel issues.

- The Division of Health Care Access and Accountability (DHCAA) is responsible for administering programs such as Medicaid, BadgerCare, FoodShare, SeniorCare and disability determination.

- The Division of Long Term Care (DLTC) oversees the provision of long-term support options for the elderly and people with disabilities. DLTC also operates the Department's institutions for persons with developmental disabilities.

Other state departments work closely with the State Mental Health Authority on a regular basis including the following:
The Department of Children and Families (DCF) responsibilities include public child welfare, regulation and licensing of child caring facilities, youth development and a broad range of community programs. It oversees the Wisconsin Temporary Assistance for Needy Families (TANF) programs, called Wisconsin Works (W2), which is designed to move welfare recipients into the labor force. It also provides the direct administration and operation of Milwaukee County's Child Welfare System.

Department of Commerce. The Department of Commerce administers the state’s economic development as well as administers financial assistance for local government and businesses. The agency is also responsible for providing housing assistance to benefit low-income and moderate-income households, as well as administering state and federal funding to combat homelessness. Their responsibilities include the oversight of the Projects for Assistance in Transition from Homelessness (PATH) program. The DMHSAS has a formal Memorandum of Understanding with the Department of Commerce about how the departments will work together to improve services for people who are homeless and have a mental illness.

Department of Corrections (DOC). The Department of Corrections administers the state adult prison, probation and parole systems, along with administering the oversight of the local juvenile justice system. The DOC contracts with the DMHSAS to run the state prison inpatient mental health facilities.

Department of Military Affairs, Division of Emergency Management. This department has responsibility for developing and implementing the state emergency operations plan, provides assistance to local jurisdictions in the event of a disaster; and administers private and federal disaster and emergency relief funds.

Department of Regulation and Licensing (DRL). The Department of Regulation and Licensing is responsible for credentialing and regulating various professions and occupations in the state. The DRL also investigates and prosecutes complaints against credential holders.

Department of Veteran’s Affairs. This department provides educational and economic assistance to eligible veterans. It also operates a variety of facilities, services and supports that provide support for Wisconsin’s veterans who are incapacitated due to age or disability.

Department of Workforce Development (DWD). This department is responsible for a variety of work-related programs designed to connect people with employment opportunities in Wisconsin. It also is responsible for job centers, job training, placement services as well as employment related services for people with disabilities through their Division of Vocational Rehabilitation.

Department of Public Instruction (DPI). This department is independent of the Governor, with an elected constitutional officer, the State Superintendent of Public Instruction. DPI provides direction and technical assistance for public elementary and secondary education in Wisconsin. They offer a broad range of programs and professional services to local school administrators and staff; distributes state and federal school aids; works to improve curriculum and school operations; and ensures education for children with disabilities.
Organization of the State Mental Health Authority

The Division of Mental Health and Substance Abuse Services (DMHSAS) is the designated State Mental Health Authority that directs public mental health services in Wisconsin. The Division is comprised of the Division Administrator, John Easterday, the Deputy Administrator, an office associate, three program units, and four direct care facilities. The Bureau of Prevention Treatment, and Recovery (BPTR) is one of the three program units and is responsible for activities related to implementation of the MHBG. The BPTR currently consists of three Sections and 33.9 FTE’s including the Director and the Director’s office associate.

Bureau of Prevention Treatment and Recovery

Mental Health Services and Contracts Section
- The Mental Health Services and Contracts Section is responsible for monitoring the programmatic and administrative guidelines for the provision of mental health outpatient services throughout the state.
- The section plans and monitors the implementation of the MHBG including the creation of the federally-required annual Mental Health Plan and Implementation Reports. Staffing for the Wisconsin Council on Mental Health is provided by this section.
- Some integrated MH/Substance Abuse functions are the responsibility of the Mental Health Services and Contracts Section.
- The section is responsible for mental health and substance abuse programming for the deaf and hard of hearing and Pre Admissions Screening and Resident Review (PASRR).
- The Mental Health Services and Contracts Section monitors CSPs for adults with severe and persistent mental illness reside as well as programs that target housing and staff coordinate with the Department of Commerce on homeless issues.
- Finally, all evaluation functions for mental health and substance abuse reside in this section including the management of the Human Services Reporting System (HSRS), Data Infrastructure Grant (DIG) projects, evaluation design, and data analysis.
- The Mental Health Services and Contracts Section has 6.5 FTEs and a .5 LTE.

Substance Abuse Services Section
- The Substance Abuse Services Section provides a focus for services and programs designed primarily for individuals with substance abuse issues.
- Substance abuse and prevention programs have been consolidated within this section from across the bureau and include oversight of the substance abuse administrative rules, Access to Recovery, methadone programs, the Intoxicated Driver Program (IDP) and the injection drug use program.
- The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is administered from the Substance Abuse Services Section.
- The Substance Abuse Prevention and Treatment State Plan (SAPTBG application) is created and monitored and staff provide general oversight of the implementation of the plan.
- Staffing for the State Council on Alcohol and Other Drug Abuse (SCAODA) is provided from this section.
- Responsibility for substance abuse prevention programming also resides in this Section.
- The Substance Abuse Services Section has 9.0 FTEs.

Integrated Systems Development Section
- The Integrated Systems Development Section has 11.4 FTEs and one .5 LTE.
• The Children Youth & Families Unit is an integrated unit and has 6 FTEs who work on children's issues with co-occurring disorders, prevention/early intervention, Substance Abuse Child Care Grants (SPIT), Substance Abuse contract administration and substance abuse teleconferences.
• Additionally, the staff in the Division of Long Term Care’s Children Long Term Waiver unit provide support for children in the Children’s Long Term Support SED Waiver Program.

Children, Youth, and Families Unit
  o The Children, Youth, and Families Unit addresses the special needs of children, and families who have mental health and/or substance abuse disorders.
  o One of the primary functions of the Children, Youth, and Families Unit is to address the children with serious emotional disturbance and their families and other children who may not meet the criteria of SED, but are involved in two or more systems of care. An example of a program that serves children with SED and their families is the Integrated Services Program. It provides a "wraparound" approach through comprehensive systems case management for children and their families. The Coordinated Service Teams Program for children and their families also provides a comprehensive systems approach to case management for children that are involved with more than one system of care, but may not meet the definition of severely emotionally disturbed.
  o All children’s mental health and substance abuse programs and services are consolidated in this unit. Staff in the Children, Youth and Families unit work to strengthen existing integrated mental health/substance abuse approaches and implement new integrated approaches where needed.
  o The unit has 6 FTEs that provide contract monitoring, technical assistance, training, and programmatic guidance to the Integrated Service Projects, Coordinated Service Teams, and Hospital Diversion programs targeted for children with SED who may also have substance abuse disorders. (Coordinated Services Teams also serve children without SED who are involved in two or more systems.)
  o The unit is responsible for the Child Welfare Initiatives, prevention and early intervention programming, and programs to benefit infants such as the Infant Mental Health Initiative.
  o Unit staff also assists in monitoring the Comprehensive Community Services (CCS) benefit for children, providing clinical consultation services for individuals with substance abuse and/or mental health disorders, agencies providing services and monitoring child and family advocacy activities.

Systems Transformation Unit
  o The Systems Transformation Unit is responsible for the implementation and monitoring of systems-level initiatives for adult and children's mental health and substance abuse service systems.
  o Most initiatives in this unit focus on systems development and training for local administrators and providers on substance abuse and mental health treatment.
  o Unit staff focus on the implementation of evidence-based practices within the system of care across Wisconsin for children with serious emotional disorders and adults with serious mental health disorders.
  o Unit staff will implement and monitor the Mental Health/Substance Abuse Transformation Initiative with a focus on integrated mental health/substance
abuse screening and treatment, managed care, quality improvement, and the promotion of recovery-focused services and systems.

- Monitoring the implementation and development of recovery-based outcomes is conducted through contracts and support to the Recovery Implementation Task Force.

**State Mental Health Institutes**

Mendota Mental Health Institute, a psychiatric hospital operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services, specializes in serving patients with complex psychiatric conditions, often combined with certain problem behaviors. Mendota provides a secure setting to meet the legal and behavioral needs of our patients. Mendota also operates outpatient treatment services for individuals in the community.

Winnebago Mental Health Institute is a psychiatric hospital owned and operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. Winnebago specializes in serving children, adolescents and adults with complex psychiatric conditions that are often combined with challenging behaviors. Winnebago provides a secure setting to meet the legal, behavioral, treatment and recovery needs of patients.

**Secure Treatment Facilities**

The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs. A youth’s motivation for positive change is also part of that assessment. Parents or guardians receive program and treatment review reports during a youth’s stay on MJTC.

Sand Ridge Secure Treatment Center offers a range of treatment programs for its patients designed to meet the specific needs of sexually violent persons. The inpatient treatment program consists of several phases and components with a multi-disciplinary approach. It is based on a psycho-social rehab model with an emphasis on cognitive-behavioral and relapse prevention techniques. The length of time in treatment is dependent upon successful program completion as evidenced by the patient's consistent demonstration of mastery of self-management skills.

The Wisconsin Resource Center (WRC) is administered by the Wisconsin Department of Health Services in partnership with the Wisconsin Department of Corrections. WRC is a specialized mental health facility established as a prison under s. 46.056, Wisconsin Statutes. WRC is also identified as a treatment facility for the placement of Sexually Violent Persons (SVPs) detained or admitted pursuant to Chapter 980, Wisconsin Statutes. The facility operates as a secure treatment center and is managed by the Division of Mental Health and Substance Abuse Services. The budgeted capacity of WRC is 404: 344 male inmates transferred from Wisconsin Department of Corrections (DOC) Division of Adult Institution prisons for mental health care and 120 men detained or committed under the SVP program pursuant to Chapter 980 of the Wisconsin Statutes.
Wisconsin

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
Section 1 - Description of State Service System

2. New Developments and Issues

Directions: New developments and issues that affect mental health service delivery in the State, including structural changes such as waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Expansion of Supplemental Security Income (SSI) Managed 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:

- 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 that 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, e.g., persons with co-occurring substance abuse and mental illness as well as trauma survivors, and involve consumers in their treatment,
- developing recovery principles and RESPECT in contract and require/encourage partnerships between agencies serving adults with disabilities and medical managed care experience, and
- implementing 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: 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, Menominee, Oconto, Shawano, Waushara, Marquette, and Green Lake.


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 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 mental illness or substance abuse issues. Issues related to the expansion of Family Care Expansion include:

1. **Unknown impact on 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.

   - Because in many counties it is possible that the same infrastructure supports a number of different populations (individuals with mental health and substance abuse issues, individuals who are developmentally disabled, physically disabled and older adults), the shift of the developmentally disabled, physically disabled and older adult populations to Family Care could have an impact on the infrastructure left to serve the MH and SA populations through the county systems.
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 providers with sufficient competency to serve consumers through the public mental health and substance abuse systems.
   
   - It is reported that approximately 55 percent of FC recipients have a 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, 2009. This is approximately half of the 55 percent of FC enrollees reported to have a diagnosis of severe mental illness.

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 are allocated for a study of the impact of the 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, cost shifting to 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.

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. 54.17 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 those who are elderly 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 Benefit 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 HealthCheck “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 HealthCheck “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

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.

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. The Secretary 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.

Children's Long-Term Support (CLTS) Waivers

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. 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, 2008, there were 329 children waiting for intensive in-home autism services through the CLTS Waivers. In 2008, numbers of children served who had the following disabilities include: developmental disabilities, 2650; physical disabilities, 252; and serious emotional disturbances, 1014. 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 service through the CLTS Waivers.

**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.

**Shortage of Psychiatric Providers 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. 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, Thomas and Holzer 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 most appropriate mental health services to Wisconsin youth. Critical need for more C/A Psychiatrists is shown by the September 2007 report by the National Institute on Health (NIH) on increases in diagnosis of bipolar disorder in young people.

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.

**ForwardHealth InterChange (new Medicaid Management Information System) Implementation**

The new Medicaid Management Information System (MMIS) called ForwardHealth 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.
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/lsb/code/dhs/dhs035.pdf

*See Adult Legislative Initiatives and Changes Section for Further Details on the Outpatient Rule Revision.
Wisconsin

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.
Section 1 - Description of State Service System

3. Legislative Initiatives

**Directions:** Legislative initiatives and changes, if any.

Legislative Initiatives

*Mental Health and Substance Abuse Parity*

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 Joint Finance 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 and was a 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 vote. A companion bill was introduced in the Assembly late in the session. The bill could not be acted on before the session ended.

Parity has been achieved at the Federal level. It is unclear how this policy will affect Wisconsin.

*Informed Consent for Admission of Minors to Inpatient or Outpatient Mental Health Treatment*

An additional issue is that the mental health laws distinguished between minors under 14 years of age and minors 14 years of age or older with regard to giving informed consent for treatment. No distinction existed between a minor under 14 years of age and a minor 14 years of age or older with regard to treatment for alcoholism or drug abuse. In May 2006, Wisconsin Act 444 was enacted and eliminated the distinction between these two groups of minors with regard to treatment for mental illness under the mental health laws by changing the rights of minors 14 years or older to be the same as those for minors under 14 years of age.

Specifically, this Act eliminates the requirement that a minor 14 years of age or older:

- Provide his or her written informed consent in addition to that of his or her parent or guardian before he or she received outpatient treatment or psychotropic medication and treatment for severe mental illness. A minor’s consent is permitted, but not required;
- To execute the application for voluntary admission to an inpatient facility without the parent or guardian’s consent before the minor may be admitted to the facility for treatment of severe mental illness;
- To be discharged from inpatient treatment for severe mental illness or developmental disability within 48 hours after solely requesting the discharge, except for a minor whose
parent or guardian refused to consent to admission or was unable to be found or for whom there is no parent with legal custody and who was admitted to an inpatient facility after a hearing;

- To be transferred from a juvenile correctional facility to an inpatient facility for treatment for severe mental illness; and
- To have the right to object to access to his or her court or treatment records by his or her parent, guardian, or person in the place of a parent.

An important change between the former statutory language and language in Act 444 is deletion of the word "voluntary" when referring to admission of a minor. This change ensures that all minors being admitted to inpatient treatment have a verified admission petition which is reviewed by the court. A potential problem being encountered with the implementation of the new law is that not all counties or providers may be aware of it and may possibly not be enforcing it. Also, as the process will involve more staff time and paper work, as well as more court reviews, some providers and counties may desire to avoid implementing the new law.

The Federal NICS Improvement ACT (HR 2640)

On January 8, 2008, President Bush signed into law the NICS Improvement ACT (HR 2640), a law that provides $250 million annually to states that implement laws such as AB70. This bipartisan bill, supported by the NRA, provides guidance to participating states on how to provide relevant and accurate records to the FBI. The new law provides an incentive to states to report people who are ineligible to buy guns. It authorized up to $250 million a year for five years for states to help pay the cost of providing the records, and threatens to withhold federal anti-crime funds from states if they fail to act.

Bills AB424/SB 216 and AB70/SB 44-Wisconsin's Legislation under the Federal NICS Improvement ACT (HR 2640)

In the 2007-2008 Legislative Session, Bills AB424 and SB216 were developed to prevent people committed involuntarily for mental health reasons from purchasing a firearm. These bills are in response to the tragic events at Virginia Tech on April 16, 2007, where a gunman killed 32 people and himself.

These bills related to adjudications for involuntary commitment, appointment of a guardian of the person, and protective placement or protective services, background checks for the purchase of handguns, and requiring the exercise of rule-making authority. AB424 and SB216 were not passed.

During the 2009-2010 Legislative session, bills AB70 and SB44, which address the same issue and are constructed similar to AB424 and SB216, were developed. The bills were constructed to ensure that Wisconsin does not go beyond what is required by the federal law in any way which might stigmatize or discriminate against persons with mental illness who may be subject to being listed on the NICS. Specifically the bill requires that the state report only that the individual is not eligible to purchase a handgun, but it does not allow information to be shared that would indicate the reason is related to a mental illness. The law requires that the information gathered and reported to the NICS cannot be released elsewhere. And, finally, it requires that when an individual is not longer under involuntary commitment that their name be removed from the NICS. These were modifications to the bills originally introduced last session that advocates requested and received. There was an amendment to AB70 introduced in the Assembly on July 8, 2009.
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 of 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://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf](http://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf)

*For more detail on the Revision of DHS 35, see Adult Section: "Legislative Initiatives and Changes."

**Wisconsin has Passed a Law Requiring that Law Enforcement Include Mental Health Clinicians in all Emergency Detentions to State Mental Health Institutions**

The 2009-2011 biennial budget requires that law enforcement personnel consult with county mental health crisis staff prior to doing an emergency detention. In the past language had been crafted in Chapter 51 to that effect, but had not been effective in enforcing this policy statewide. "Best Practices" were developed also several years ago which required mental health/crisis staff to be involved with Law Enforcement any time that an emergency detention was being considered. In many counties there had been improvement in this area, resulting in a decrease in emergency detentions and hospital admissions. The new budget requires that all counties adopt and enforce this policy.

**2007 Wisconsin Act 108 to Remove Barriers to Health Information Exchange**

Health information exchange (HIE) is necessary to improve the quality and safety of health care. Variations in health information privacy law create barriers to the development of HIE in Wisconsin. Act 108 is a significant step toward removing these barriers. It provides physicians and patients with additional and more reliable information as they make important decisions about what health care treatment is best and safe for patients. In addition, this Act better aligns Wisconsin law with federal HIPAA confidentiality and privacy laws.

Extensive dialogue and collaboration with a wide range of stakeholders resulted in passage of Act 108. Specifically, the changes to Wisconsin Statute 51.30 were developed by a workgroup convened by the Department with representation from many key advocacy and provider organizations. Changes to Wisconsin Statute 146, related to general health records, were discussed with many stakeholder groups as well. There were some concerns on the part of consumers regarding how increased availability of mental health information to a wider range of providers might prejudice their treatment. A key compromise between state policy makers and consumers/advocates was the requirement to develop an anti-stigma curriculum for healthcare providers. On December 4, 2007, the eHealth Care Quality and Patient Safety Board reviewed and approved proposed statutory changes. The Assembly and Senate passed legislation in early March. Governor Doyle signed the legislation on March 17, 2008.

**Changes to General Health Information Statute--effective April 1, 2008**

2007 Wisconsin Act 108 allows re-disclosure of health information in a way that benefits electronic health information exchange while retaining some limitations on re-disclosure to protect confidentiality. Specifically, it:
1. Eliminates the requirement to document all disclosures. Health care providers are still required to document the disclosures required to be tracked under federal HIPAA laws, such as disclosures related to child or elder abuse cases or public health reporting and disclosures to law enforcement and coroners.

2. Allows health care providers to disclose health information to a patient's family, friend or another person identified by the patient and involved in the patient's care:
   - If the patient provides informal permission (rather than formal written consent) to do so.
   - If the patient is not physically available or physically or cognitively able to grant informal permission or able to determine whether disclosing the information is in the best interests of the patient and the patient would otherwise allow such a disclosure.

Changes to Mental Health Statute 51.30--effective October 1, 2008

2007 Wisconsin Act 108 allows for the exchange of information that physicians have expressed a need to receive and also allows for the exchange of information with any health care provider with a need to know by:

- Adding "diagnostic test results" and "symptoms" to the list of elements that may be exchanged without patient written consent.
- Removing the within a "related health care entity" requirement so that important health care information can be exchanged with any health care provider who is involved with the patient's care and who needs the information to properly treat the patient, regardless of whether the provider is a part of the clinically integrated setting or health plan where the patient originally received.

Written informed consent of the patient is still required to disclose information other than the specific elements permitted for exchange. For example, a patient's written consent is still required to disclose an entire consultation note or discharge summary.
Wisconsin

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
Section I - Description of State Service System

4. Description of the State's Leadership

Directions: A description of how the State mental health agency provides leadership in coordinating mental health services within the system.

How the State Mental Health Authority Shows Leadership and Coordinates with the Larger Systems

The DMHSAS is very involved in coordinating across service systems. This leadership role has been fostered over the past four years and continues to the present time. The State Mental Health Authority, Dr. John Easterday, is a member of the Executive Management Team of the Department of Health Services and interacts on a regular basis with his peers that oversee the following program areas: Medicaid, Public Health, Long Term Care, and Quality Assurance. The Executive Team develops and implements a department wide strategic plan that assures that the priorities of the department are well coordinated.

In addition, DMHSAS staff serves in leadership roles in a number of DHS cross-divisional and cross-department efforts geared towards transforming systems to improve services for people with mental health needs. Those efforts include:

- Medicaid’s Pharmacy Prior Authorization Committee and Mental Health Drug Advisors Group. These groups meet on a regular basis to provide input into Medicaid policies regarding the state’s preferred drug list and to improve prescribing practices.
- Departmental Infant Mental Health Leadership Team (IMHLT). This group’s charge is to carry out the Governor’s KidsFirst initiative to assure that children grow up healthy through the provision of appropriate socio-emotional development. The mission of the DHS IMHLT is to integrate infant and early childhood mental health principles and practices across all divisions in DHS as well as other Departments and community organizations. All divisions of the department participate with leadership from the DMHSAS.
- Seclusion and Restraint Workgroup. The DMHSAS is in the lead staff role of this workgroup focused on reducing the use of seclusion and restraint, in particular with programs serving children across the various divisions of DHS and DCF. DPI will be receiving $22,958 from the 2010 MHBG to provide training for schools on promoting positive behavior supports.
- Coordinated Services Team Executive Committee. This team led by the DMHSAS in collaboration with the Department of Children and Families, oversees the development of this initiative to assure a cross system approach to providing services and supports to children and their families using a wrap around approach. This effort focuses on changing local systems to invest in the creation of local collaborative systems of care for children.
- Child Welfare Screening Team. This team includes representatives from DMHSAS, Child Welfare and Medicaid and leads the effort to develop and implement a pilot program to provide mental health and substance abuse screening for children entering the child welfare system in 10 counties. The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of
pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, and also on the impact of trauma. The new pilot will target five counties in the northeast region of the state.

- Outpatient Mental Health Rule Revision Work Group. 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 sometime 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://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf](http://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf)

- Long Term Care Coordination Committees. Staff from the DMHSAS are involved in a number of committees working to coordinate our efforts with the Division of Long Term Care in the areas of: Aging & Disability Resource Centers, Mental Health and AODA Functional Screen, Home and Community Based Waivers, which included the development of the new Community Opportunities in Recovery (COR) Waiver to relocate persons in nursing homes who have a mental illness. During 2008, Dane County successfully implemented the COR waiver and relocated 4 individuals from their county operated nursing home.

- SSI Managed Care Implementation. The DMHSAS works with the DHCAA to expand SSI Managed Care programs and to coordinate their services with the county mental health and substance abuse systems. Through the SSI Managed Care initiative many persons with mental illness are now receiving their health care services through HMOs.

- BadgerCare Plus Development. The DMHSAS worked with the DHCAA to develop a plan for mental health and substance abuse benefits in the expanded health care coverage for low income children and 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.

In addition to these committees and workgroups across the Department, the DMHSAS also works collaboratively to jointly fund grants and contracts to achieve common goals, often resulting from the work in these committees or groups, including:

- Braided funding from the Mental Health Block Grant (MHBG), child welfare IV – E funding, and the Substance Abuse Block Grant to expand the Coordinated Services Teams in the state;
- Braided funding with both MHBG and child welfare funding for the implementation of the Child Welfare Screening Pilots that began with the FFY 07;
- Working together, the Infant Mental Health Leadership team developed joint goals to fund staff and develop of the state’s Infant and Early Childhood Mental Health Plan. The Leadership team has developed a 2008 Annual Report which details all of the Department's activities related to Infant Mental health and makes policy recommendations for further actions by the Leadership team.

DMHSAS staff also provides leadership roles in a number of cross-departmental efforts, including:

- Human Services Emergency Management. The DMHSAS has a staff person who serves as one of the lead DHS staff team members to plan for human service population needs in emergencies and who provides staffing support at the state’s Emergency Management center in the event of a local or state disaster or other critical situation.
- Trauma Summit Work Group. The DMHSAS provided leadership to jointly plan and hold a statewide summit on trauma. This effort included individuals from across the
divisions at DHS as well as other departments, consumers, advocates and local government representatives.

- A trauma Coordinator was hired in DMHSAS in April of 2008. The trauma coordinator is responsible for collaborating with consumers and other mental health and substance abuse systems' stakeholders to plan, develop and implement trauma informed care in community-based mental health, substance abuse and other human service settings. In addition to increasing trauma-related awareness in the services community, this initiative will improve mental health and substance abuse services to people impacted by trauma.

- Mental Health Criminal Justice Advisory Committees. DMHSAS staff serve on a number of committees with the Department of Corrections, Office of Justice Assistance, and the Mental Health Council, to coordinate improvements to the provision of mental health services to inmates and those individuals returning to the community.

- DHS has developed memorandums of understanding with the Department of Workforce Development (DWD) and the Division of Vocational Rehabilitation regarding support for employment services for people with mental health needs. The two agencies have promoted the use of Supported Employment as an evidence-based approach to services.

- Governor’s State Council on Alcohol and Other Drug Abuse. DMHSAS provides staff to this state council that focuses on prevention and reducing the impact of alcohol and other drugs in the State. One common issue is the need to promote integrated treatment for people with co-occurring mental health and substance abuse disorders is an area shared in common with this group. Members of all the major state agencies are represented.

- Wisconsin Council on Mental Health. The DMHSAS provides support to the Governor’s appointed council that serves as the state planning council for the Mental Health Block Grant. Membership includes individuals from other state agencies that are involved and interested in mental health services which are noted in the membership of the Council in that section of the plan.

- A summit meeting on seclusion and restraint practices with children who are receiving services in the community setting in Wisconsin was held in June 2007. The Department of Health Services is redesigning public policy on the use of seclusion and restraints. Additionally, during 2007, a Seclusion and Restraint Workgroup was convened to analyze current legislation and regulations across DHS Divisions and programs. Subcommittees of the workgroup were formed to study: legislation and regulation; development of a DHS technical assistance and training plan for providers and administrators; data collection; and identification of prohibited practices. The Wisconsin Department of Health Services (DHS) has gone on record regarding the detrimental effects of these coercive activities, convened workgroups to reduce their use, and over the past 15 months has sponsored three training programs for approximately 22 providers and 460 participants that have focused on the goal of reducing seclusion and restraint in community-based programs regulated by DHS and the Department of Children and Families (DCF).

- A Departmental memo was released in January 2009 that prohibited certain practices in the use of emergency seclusion and restraint.

- The Integration of Physical Health, Mental Health, Substance Use, and Addiction is an initiative developed between the Division of Public Health and the Division of Mental Health and Substance Abuse Services. A Joint Integration Statement was developed collaboratively and has been endorsed by all DHS Divisions, the Secretary of DHS and several external partners. The initiative will promote systemic changes needed to improve health outcomes for individuals, children/youth, families, veterans, and communities in Wisconsin. In acknowledging mental health and physical health are interrelated, services may be better integrated to produce more efficacious treatment.
These principles address whole health in assessment and treatment. The whole person, their family and community, are addressed.

- In order to support the development of a comprehensive system of coordinated care for children with severe disabilities and their families, the Department established the Children Come First Advisory Committee, with representatives of county departments, the Department of Public Instruction, educational agencies, professionals experienced in the provision of service to children with severe disabilities, families with children with severe disabilities, advocates for such families and their children, the subunit of the Department of Workforce Development that administers vocational rehabilitation, the technical college system, health care providers, courts assigned to exercise jurisdiction under Chapters 48 and 938, child welfare officials, and other stakeholders.

In addition to these standing councils, committees and workgroups, the DMHSAS also enters into a variety of contracts, agreements, and memorandums of understanding with other departments:

- The DMHSAS has a formal Memorandum of Agreement with the Department of Commerce (Commerce) addressing how the two departments will work together to improve services for people who are homeless and have a mental illness. This effort has included providing funding to the Department of Commerce for efforts to expand the state’s efforts to do assertive outreach to individuals who are homeless and have a mental illness.

- The Department of Corrections (DOC) contracts with DMHSAS to run the state prison inpatient mental health facilities.

- DMHSAS works closely with the Department of Public Instruction (DPI) on many common issues including providing a contract with MHBG funding for technical assistance to local school districts on efforts to expand their suicide prevention efforts; working together to develop curricula for local school districts on mental health and anti-stigma efforts; and, establishing a memorandum of agreement to transition youth with disabilities into the adult mental health system.
Wisconsin

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

1. Service System's Strengths and Weaknesses

Directions: A discussion of the strengths and weaknesses of the service system.

Comprehensive System of Care

STRENGTHS IN THE ADULT SYSTEM

Information regarding strengths in the adult public mental health system 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 has been a reduction in long term institutionalization of mental health consumers in hospitals and nursing homes.

There has been a reduction in the number of persons who have a serious severe mental illness without a significant medical/physical condition residing in a hospital or nursing facility on a long-term basis in Wisconsin. At any one time, there are not more than 10 to 12 individuals staying for more than six months in the state mental health institutes. In 2008, nursing homes in the state had 471 persons with serious severe mental illness who required specific psychiatric rehabilitation services. This is a lower per capita rate than most other states. This is due in part to a decrease in the number of nursing homes and psychiatric beds, as well as an increase in community support programs. This has led to an improved quality of life for consumers and a cost savings for counties and the state.

Wisconsin is working to expand mental health services to better address consumers needs.

The primary issue to be addressed regarding the epidemiology of severe mental illness in Wisconsin is increasing the availability of mental health services to more closely match the need within the state. The strengths in this area are the State's and counties' ongoing efforts to increase services available to consumers such as the creation of CCS described above and the continual effort to increase the number of CSPs across the state. Wisconsin is always trying to increase the number of evidence-based mental health programs and services available in the state to serve more consumers.

However, according to Wisconsin's prevalence estimates discussed in more detail later in the Plan, an estimated 5.66 percent of adults 18 years of age and older have a serious severe mental illness. Out of 4,280,361 adults in the state, this means that 242,386 adults have a serious severe mental illness compared to the 79,740 adults were reportedly served through the public mental health system in CY 2007 according to the State's Human Services Reporting System (HSRS). Based on the estimated prevalence of 242,386 adults with SMI in Wisconsin, the public mental health system served 33 percent of the adults with SMI in Wisconsin. Wisconsin anticipates that the number of adults served through the public system is 30 percent underreported based on a
review of the number of clients served by counties. In addition, some consumers are served through private mental health providers. Nevertheless, making adjustments for these two factors would still not adequately address the size of the gap between the estimated number of adults with serious severe mental illness and the number of adults treated.

Health care coverage is required to obtain mental health services. Based on results of the 2007 Family Health Survey, the majority of Wisconsin residents in 2007 had health insurance for the entire year. That is, they were continuously covered during the 12 months prior to the survey interview. An estimated 4,937,000 residents (91 percent) were insured for all of the past 12 months.

However, an estimated 265,000 Wisconsin household residents (five percent) had no health insurance of any kind during the entire year. Another 224,000 residents (four percent) had health insurance for part of the year and were uninsured for part of the year. Together, an estimated total of 488,000 residents (nine percent) were uninsured during part or all of 2007. Those more likely to be uninsured for the entire year included people aged 18-44, Hispanics, those with incomes below the federal poverty level, and those who were self-employed. Mental health consumers tend to fall in the category of those with incomes below the federal poverty level.

The Department of Public Instruction is expanding the state's Youth Suicide Prevention initiative.

The Department of Public Instruction (DPI), Mental Health America (MHA) and the DDHS/Bureau partnered in 2007 to link suicide prevention efforts to ongoing projects on children’s mental health. $30,000 of the MHBG was allocated to Suicide Prevention in 2007 and 2008. Focus was on three distinct areas: classroom curriculum, toolkit development and duplication, and children’s mental health web casts for schools.*

*For more information on Suicide Prevention see section "Recent Significant Achievements" in the Children's Plan.

Consumers are securing employment through CCS and CSPs.

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 implemented the following strategies to encourage and foster better employment opportunities for people with severe mental illnesses: funding a peer specialist development position to foster employment opportunities within the mental health system for peers; developing a training curriculum for peers by peers to educate consumers in setting vocational goals, writing resumes and wellness on the job, educating employers on mental health issues in the workplace, creating mental health friendly workplaces, and promotion of best practices and policies for workplace accommodation guidelines. Outcomes for 2008 include:

1. In 2008, thirty consumers went through the personal career planning process.
2. By January, two of them gained employment and one started technical college.
3. In 2009, the curriculum is being distributed to individual workers at various types of agencies and organizations and among the state's peer network.
With these partners the initiative is beginning to integrate the content and methods with all types of individual planning, supported employment, and peer specialist placements.

2. Provider Capacity

*State agency initiatives addressing adult mental health are being better coordinated.*

To increase coordination with other State agencies and to provide services to consumers with multiple agency needs, Wisconsin has prioritized collaborative State agency initiatives. The DHS and the Wisconsin Council on Mental Health's Criminal Justice Committee operate in a collaborative effort with the Department of Corrections and the Social Security Administration to improve the availability of Social Security benefits for offenders with disabilities immediately upon release to the community. The Committee’s strategic action plan is to reintegrate offenders into the community by increasing benefits availability for mental health services as they leave prisons and in the future county jails, training community corrections agents and providers, and diverting non-violent offenders with serious mental health/AODA issues into treatment. The DMHSAS has collaborated with DCF on promoting screening of children in child welfare for their mental health needs.

*Wisconsin has a county-based system.*

Wisconsin allows its counties to have local control over funding. This allows for flexibility. Also, consumers can present themselves locally to an agency that has the responsibility for the services, so the agency with the responsibility is not remote like state level services. Additionally, being county based, trends can be spotted and responded to very rapidly. Good relationships with all of the agencies in the counties such as schools, churches, local providers, and healthcare help to establish service delivery systems to address unique needs local populations. County mental health centers work with local agencies on prevention and early intervention activities. Plans/services are individualized both in terms of consumer needs and being able to work with providers to tailor make wrap-around services. County mental health centers are intimately aware of local resources and work hard on building capacity. They also work closely with the schools in order to minimize transition issues for kids leaving school and entering the adult service system. Additionally, they know the quality of providers in the county. Finally, there is local accountability, as so many of the funds for mental health come from local taxing bodies.

*Wisconsin has effective mental health programs for individuals who are homeless.*

One of the strengths of Wisconsin's adult mental health system for individuals who are homeless is its Project for Assistance in Transitioning from Homelessness (PATH) initiative funded through a grant from the Center for Mental Health Services. 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 one-time rent payments to prevent eviction. The PATH initiative is the only State-administered program providing mental health services to individuals who are homeless. Otherwise, mental health service provision for individuals who are homeless is left to individual counties and private human service agencies.
Wisconsin passed a law that requires law enforcement personnel in counties to include mental health clinicians in all emergency detentions to state mental health institutions.

The 2009-2011 biennial budget requires that law enforcement personnel need to consult with county mental health crisis staff prior to doing an emergency detention. In the past language had been crafted in Chapter 51 to that effect, but the policy had not been enforced statewide. "Best Practices" were developed also several years ago regarding this issue. In many counties there had been improvement in this area, resulting in a decrease in emergency detentions and hospital admissions. Now all counties are required to provide coordination between the mental health and law enforcement systems for emergency detentions.

3. Funding

Medicaid coverage for mental health consumers has improved.

One of the strengths of Wisconsin's community-based adult mental health system is its Medicaid policy. Wisconsin's Medicaid policy covers a wide range of adult mental health services including the Community Support Programs and the CCS benefit mentioned above. The Medicaid policy has covered psychotropic medications and used prior authorization sparingly in the past to allow physicians and consumers access to the most effective medications. The Governor's 2008-2009 Budget proposal included an increase in the reimbursement rate for psychiatric services to remove barriers to provider participation in some areas. The Medical Assistance Purchase Plan provides eligibility for individuals with disabilities who return to work and are no longer eligible for regular Medicaid.

Additionally, Wisconsin developed a home and community-based waiver program called Community Opportunities in Recovery (COR). The COR waiver program was created to relocate to a community setting persons who have a serious severe mental illness and require a specialized psychiatric rehabilitative services, and reside in a Medicaid-certified nursing facility. Also, Wisconsin developed an innovative psychosocial rehabilitative services program, Comprehensive Community Services, as a Medicaid fee-for-service benefit.

The 2009-2011 State Budget has added additional funding for community mental health services.

The 2009-2011 biennial budget adds additional authority for the state/counties to launch a new Community Recovery Services Medical Assistance benefit through a 1915i waiver. This new program will allow providers to bill Medicaid for in-home supportive services, supportive employment and peer/advocate supports and is part of the State Plan. The budget also adds $1 million in general purpose revenue for community services in 2010 and an additional $3 million in 2011.

4. Data

Wisconsin utilizes its Data Infrastructure funds to collect better data on evidence-based practices.

In FFY 2008, Wisconsin continued to work toward the implementation of new evidence-based practices. Wisconsin submitted a Data Infrastructure Grant application for FFY 2008 to collect
data on the use of evidence-based practices. Counties were surveyed through the use of a web survey tool about the evidence-based practices they currently use. Funding from the Data Infrastructure Grant has been used when possible and supplemented with Mental Health Block Grant funds when necessary, but cost was minimized for staff time because the web survey tool was purchased previously. The survey is helping begin the process of defining EBP’s for counties as well as yielding data on current use and future needs for EBP’s.

**Wisconsin has created a mental health data warehouse with merged HSRS and Medicaid data.**

One of Wisconsin's strengths in both the adult and child systems is its efforts to merge county-based HSRS mental health consumer data with the state Medicaid fee-for-service data in a data warehouse. The top priority for data integration is linking the HSRS mental health and substance abuse (MH/SA) data with the Medicaid MH/SA data. The HSRS mental health and substance abuse data is currently linked and available for analysis in the data warehouse. In addition, the Medicaid MH/SA data is now available for analysis in the data warehouse and has also been linked to the HSRS MH/SA data. Mental health and substance abuse staff in the DMHSAS are now beginning to access this data for analysis and report writing.

**5. Stigma**

**Stigma is being addressed in the state.**

The necessity to eliminate stigma and discrimination associated with severe mental illnesses and barriers created, has been identified in research, Wisconsin survey data, and Healthiest Wisconsin 2010, the State Public Health Plan. Wisconsin United for Mental Health (WUMH) is a coalition of state, nonprofit, advocacy, and consumer organizations and agencies dedicated to educate and increase awareness about severe mental illnesses as real, common, and treatable, to encourage people to seek treatment, and to promote recovery. WUMH has undertaken many initiatives and trainings to promote awareness of mental health and severe mental illnesses through consumer and family spokespersons, along with WUMH presenters. Research shows that, in addition to providing accurate and factual information, the most effective way to change attitudes and beliefs about severe mental illness and to combat stigma is through personal one-to-one with a consumer or a family member. Through WUMH, educational trainings, outreach, and materials have targeted employers, schools, media professionals, health care providers, and communities.

**WEAKNESSES IN THE ADULT SYSTEM**

Information regarding weaknesses in the adult public mental health system 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 MA recipients in the state. Dental care services received increased focus during contract negotiations with HMOs to increase access, as only a few HMOs cover dental services. This is a particular issue with detrimental health outcomes for
adults with serious and persistent severe mental illness, due to the side effects of many psychotropic medications.

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. CCS will be 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. 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. Additionally, there is a lack in other types of mental health providers, such as social workers, clinicians and other direct service workers.

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 DMHSAS continually makes a conscious effort to implement 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 resultant 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. Some have links to the local Human Services Provider, 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 emergency services and hospitalization to inmates.

The State Deputy Sheriff’s Association 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 Sheriffs Association and the Wisconsin Counties 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-entering the community attempt to navigate the helping systems, they often face considerable stress that undermines their psychological stability and gains made 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 little community resources that do exist.

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 served through the county mental health system, this means that a significant increase the demand for public mental health services will occur.

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 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 New Freedom Commission'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 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 occur at the county level.

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. Primary care physicians should be aware of the psychiatric medications mental health patients are on and whether they smoke and provide services that address related health issues. It is clear that this is not adequately addressed at a state level or nationally as it has been reported 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 high cost. 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 MOUs 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/county to launch the new MA-Benefit: Community Recovery Services through a 1915(i) waiver. This new program will allow 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.

**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 is a requirement unique to mental health services; 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 has concerns with the 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 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.
Wisconsin

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

2. Unmet Service Needs

Directions: An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

UNMET SERVICE NEEDS IN WISCONSIN

1. Access to Services

Severe mental illness and poverty is prevalent in the state.

However, according to Wisconsin's prevalence estimates discussed in more detail later in the Plan, an estimated 5.66 percent of adults 18 years of age and older have a serious severe mental illness. Out of 4,280,361 adults in the state, this means that 242,386 adults have a serious severe mental illness compared to the 79,740 adults that were reportedly served through the public mental health system in CY 2007 according to the State's Human Services Reporting System (HSRS). Thus in CY 2007, the public mental health system served 33 percent of the adults with SMI in Wisconsin.

In addition, some consumers are served through private mental health providers. Nevertheless, making adjustments for these two factors would still not adequately address the size of the gap between the estimated number of adults with serious severe mental illness and the number of adults treated.

Based on results of the 2007 Family Health Survey, the majority of Wisconsin residents in 2007 had health insurance for the entire year. That is, they were continuously covered during the 12 months prior to the survey interview. An estimated 4,937,000 residents (91 percent) were insured for all of the past 12 months.

However, an estimated 265,000 Wisconsin household residents (five percent) had no health insurance of any kind during the entire year. Another 224,000 residents (four percent) had health insurance for part of the year and were uninsured for part of the year. Together, an estimated total of 488,000 residents (nine percent) were uninsured during part or all of 2007. Those more likely to be uninsured for the entire year included people aged 18-44, Hispanics, those with incomes below the federal poverty level, and those who were self-employed. Mental health consumers tend to fall in the category of those with incomes below the federal poverty level.

Adults who are homeless and have severe mental illness 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 severe mental illness remains. While there are an estimated 7,316 individuals who are homeless with a serious severe mental illness in Wisconsin, the PATH initiative served over 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. 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.

2. Provider Capacity

*Coordination of services for mental health 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 programs. Opportunities for leadership in planning collaborative initiatives and facilitating collaboration among local providers still exist. CCS will be an opportunity to begin collaborative efforts with the ability to fund integrated mental health and substance abuse treatment.

*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. Primary care physicians should be aware of the psychiatric medications mental health patients are on and whether they smoke and provide services that address related health issues. It is clear that this is not adequately addressed at a state level or nationally as it has been reported that people with severe mental illness die an average of 25 years earlier than a person without severe mental illness.

*Many counties in Wisconsin are rural and programs to serve rural individuals with severe mental illness 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 DMHSAS continually makes a conscious effort to implement 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.
There is a shortage of psychiatric and other mental health providers.

A shortage of psychiatric and other mental health providers exists. 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.

3. Data

There are gaps in mental health data in the state.

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.

Wisconsin's National Outcome Measures reflect a need to increase access to services and improve in other areas of the mental health system of care.

In May of 2007 the Mental Health Council spent part of their meeting discussing the National Outcome Measures (NOMS) and what they considered priority items within those NOMS. In order of priority they advised the Department to focus on increased access to services, decreasing criminal justice involvement in the individuals with mental health needs, increasing stability in housing and increasing or retaining employment and or education for the mental health population.

4. 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.
Wisconsin

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

3. **Plans to Address Unmet Needs**

   **Directions:** A statement of the State's priorities and plans to address unmet needs.

### PLANS TO ADDRESS UNMET NEEDS

1. **Access to Services**

   The CCS benefit is being expanded to serve more mental health consumers.

   As mentioned above, the creation of the CCS benefit was one of Wisconsin's major accomplishments in FFY 2004-2005. The CCS benefit allows counties to be reimbursed by Medicaid for providing an expanded array of psychosocial rehabilitation services to both adults with severe mental illness (SMI) and children with SED. 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 CSP’s 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 start-up for CCS programs.

   To date, 27 counties have received certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) 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. 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 MHBG funds to developing CCS or CSP programs. These counties are able to fund trainings and CCS program personnel, train consumers and fund consumers on their coordination committees for example, to accelerate their implementation of the program.

   *For More Details on CCS See Section "Available Services--Adults."

   **Increased access to services for adults in the public mental health system is a significant need in Wisconsin.**

   Wisconsin will use a number of different methods to increase the number of adults with access to services in the public mental health system. First, the CCS benefit will provide an expanded choice of MA-funded mental health services. Implementing tele-psychiatry (described in Criterion 4) will also provide mental health services in rural parts of the state where these services...
are currently unavailable. In addition, expansion of crisis services will also increase the number of adults with access to such services. Wisconsin continues to increase the number of certified CSPs and CCS in the state by providing $100,000 in MHBG funds annually for start-up costs. Starting in FFY 2006 and continuing in FFY 2009, the DMHSAS has begun to provide start-up funds for counties to establish new CCS programs. Increasing the number of counties that have a CSP or CCS program will bring services to more adults in new areas of the state. In addition, Wisconsin will continue to increase access to CSPs through its CSP Wait List Reduction program. A total of $1,000,000 in state funds is provided to CSPs annually to serve consumers who are on CSP wait lists.

Wisconsin's priorities for adults in rural areas will be the continual expansion of CSP, CCS and tele-health into 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 state and federal program start-up funds for CSPs and CCS projects. The start-up funds are intended to help counties build the capacity to be a certified CSP provider so they can bill Medicaid for their services. Tele-health is the use of telecommunication equipment to link mental health providers and consumers in different locations. Tele-health will allow the county to more easily attract a qualified psychiatrist and pay only for treatment time instead of the extra travel time they may pay currently. Additionally, MHBG funds have been allocated to a Workforce Development Initiative to expand access to psychiatric consultation, especially in rural areas.

Wisconsin Nicotine Treatment Integration Project (WINTIP) addresses nicotine dependence in the state.

WINTIP is a two-year planning project for integration of evidence-based nicotine dependence treatment into alcohol and other drug dependence and mental health services. The initiative is funded by the Wisconsin Division of Public Health Tobacco Prevention and Control Program and brings together tobacco control, mental health/substance use systems and government. During 2008, WINTIP staff gave presentations to community stakeholders and policy makers regarding tobacco addiction for individuals with mental health and substance abuse issues, facilitated national and statewide collaborations to address the issue, devised marketing plans, identified pivotal provider barriers, and identified pivotal patient/client barriers to recovery.

WINTIP recommendations include working toward a change in culture in both provider and consumer attitudes from one of viewing smoking as being therapeutic, or not within the primary care or psychiatric care purview to address, to viewing smoking as a serious health hazard that is a barrier to recovery and needs to be addressed. Several studies have shown that patients with a psychiatric and/or substance abuse diagnosis on the average die 25 years earlier than the general population. This is likely correlated with the fact that although 22 percent of the adult general population has a psychiatric disorder, they consume 45 percent of the cigarettes smoked in the U.S. The WINTIP initiative has a goal of educating primary care providers, psychiatric care and substance abuse providers, as well as consumers about this relationship and hopes to change the culture that is supporting this high rate of morbidity and mortality in Wisconsin mental health and substance abuse consumers. Future funding for WINTIP is uncertain because of the state's current economic situation.

Medicaid Preferred Drug List (PDL) controls costs and provides clinically sound drug therapy for recipients.
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. The Secretary of DHS formed a Mental Health Drug Advisors Group to advise her on the inclusion of Mental Health drugs on the PDL.

**Psychiatric clinical consultation is expanding to encourage best practices for prescribing medications to mental health consumers.**

In FFY 2009, the DMHSAS will expand psychiatric clinical consultation by contracting for training and technical assistance.

**A priority for Criterion Four is the provision of mental health services to adults who are homeless.**

While the PATH program has served as the primary State effort to serve individuals who are homeless with a SMI, Wisconsin is now taking additional steps beyond the PATH grant program to emphasize the importance of serving the homeless. Specifically, the DMHSAS is working to increase access to services, improve the quality of data collected for individuals who are homeless, and increase resources dedicated by the State to this area. The DHS annually issues a numbered memo to all counties regarding the use of the MHBG funds they receive. The memo details a continuing priority to target services for persons with serious severe mental illness who are homeless. In addition, the counties are instructed to prioritize the submission of quality mental health data describing individuals who are homeless. Counties have the ability to record mental health data on individuals who are homeless through the statewide Human Services Reporting System (HSRS). In the past, there has been an underutilization of the HSRS codes indicating homelessness. The memo instructs counties exactly how to record homeless status for an individual. Improvements in data reporting will allow DMHSAS and the counties to understand where services could be improved and to take action to make needed improvements. DMHSAS allocates $74,000 to improve outreach and access to benefits for individuals who are homeless and have a severe mental illness. The Department of Commerce is coordinating these efforts for 2008 and 2009.

**Independent Living Centers support individuals with severe mental illness and other disabilities across the lifespan.**

Independent Living Centers (ILC) use peer support, skills training and other independent living services to assist all people of any age with severe mental illness or another disability to meet personal goals related to their home, work and community. Centers are unique in a number of significant ways, not the least of which is governance and services are provided predominantly by people with disabilities, and those eligible are of any age, any disability, and regardless of income. ILC services are complimentary to other community-based services including managed care organizations, Aging and Disability Resource Centers, and the Division of Vocational Rehabilitation.
2. Provider Capacity

*Evidence Based Practices Pilots are being implemented across the state to improve fidelity to model programs.*

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. Three counties are implementing IDDT and two counties are implementing IMR. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation.

Evidence-Based Program grants will also be awarded in 2009 to help counties continue their implementation and quality improvement work. 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.*

*For more information on EBPs see Adult Section on "Recent Significant Achievements."

*Address Trauma in Wisconsin*

*For Details on Trauma Prevention Activities See Section "Available Services Adults."

*Wisconsin is investing in Aging and Disability Resource Centers (ADRC) to provide information and assistance disability benefits counseling.*

Aging and Disability Resource Centers (ADRC) offer the general public a single entry point for information and assistance on issues affecting older people and people with disabilities (including severe mental illness), or their families. The Division of Mental Health and Substance Abuse Services is providing 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 in 2007 and additional web-casts in 2008 to ensure that ADRC staff is better equipped to deal with the population who have mental health issues and their families. This year, staff from DMHSAS presented workshops to ADRC staff at their annual conference to assist ADRC staff to understand the functional eligibility for Wisconsin Mental Health programs and how to access them through referrals to their local mental health agencies.

As of January 2009, there were 28 operational ADRCs serving 40 counties. The ADRC of Southwest Wisconsin-North expanded to serve Crawford County. This gives 67.2 percent of Wisconsinites over age 18 access to an ADRC. DHS has received and reviewed the application from the multi-county and multi-tribal collaboration between Bayfield, Iron, Ashland, Sawyer and Price counties and the Bad River, Lac Courte Oreilles and Red Cliff tribes. The Department is working with current applicants including the multi-county collaboration between Barron, Washburn and Rusk Counties, Pepin, Buffalo and Clark Counties, Douglas County and the multi-county and tribal collaboration between Polk and Burnett Counties and the St. Croix Tribe. Discussion also continues with Milwaukee County to establish the Disability Resource Center.
3. Data

*Wisconsin will utilize its Data Infrastructure Grant funds to collect better data on evidence-based practices.*

In FFY 2008, Wisconsin continued to work towards the implementation of new evidence-based practices. Wisconsin submitted its new Data Infrastructure Grant application for FFY 2008 with plans to collect data on the use of evidence-based practices. Counties were surveyed through the use of a web survey tool about the evidence-based practices they currently use. Funding from the Data Infrastructure Grant will be used when possible and supplemented with Mental Health Block Grant funds if necessary, but cost will be minimized to staff time because the web survey tool was purchased previously. The survey is helping begin the process of defining EBP’s for counties as well as yield data on current use and future needs for EBP’s. In FFY 2009, the State plans to facilitate the dissemination of training resources to counties to implement new evidence-based practices and assess the fidelity of at least one existing evidence-based practice in the state.

*Wisconsin’s priority is to build its reporting capacity to complete all of the Uniform Reporting System Data Tables required by the Mental Health Block Grant.*

Wisconsin’s Mental Health Data Infrastructure Grant project will assist with improvements and revisions needed for data elements for the Uniform Reporting System. The primary goal is to build Wisconsin's reporting capacity to complete all of the Uniform Reporting System Data Tables. Currently, Wisconsin is able to complete all of the 21 Data Tables. Wisconsin has automated reports for the Data Tables it submits by accessing data in a mental health/substance abuse data warehouse it created with the help of previous Data Infrastructure grant funds. The standardized reports are designed based on the federal Data Table definitions. By providing query tools that allow users access to the databases in the data warehouse, standardized and ad hoc reports can be designed for program evaluation as well.

*Wisconsin has created a mental health data warehouse with merged HSRS and Medicaid data.*

One of Wisconsin's strengths in both the adult and child systems is its efforts to merge county-based HSRS mental health consumer data with the state Medicaid fee-for-service data in a data warehouse. The top priority for future data integration is linking the HSRS mental health and substance abuse (MH/SA) data with the Medicaid HMO encounter MH/SA data. The HSRS mental health and substance abuse data is currently linked and available for analysis in the data warehouse. In addition, the Medicaid MH/SA fee-for-service data is now available for analysis in the data warehouse and has also been linked to the HSRS MH/SA data. Mental health and substance abuse staff in the DMHSAS are now beginning to access this data for analysis and report writing.

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; increasing 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.
4. Funding

*Recovery principles and transformation of the mental health system is being facilitated across the state.*

Wisconsin plans to continue to spend 13.4 percent or $991,629 of its MHBG funds directly on consumer and family-focused programs in FFY 2009. This was an increase from $874,000 in FFY 2008. These include: Adult Family Support, Child/Family Support, Consumer/Peer Support and Children's Systems Change. The beginning of transformation efforts in Wisconsin began with the Governor's Blue Ribbon Commission, which was appointed in May of 1996. The Governor's charge to the Commission was to examine the mental health delivery system and the principle of a state/county partnership; the mental health services provided for children, adolescents, adults, and older adults; and the impact of stigma on community perceptions and current mental health policies.

DMHSAS began implementing transformation with the hiring of a consumer affairs coordinator and the creation of a consumer run, statewide Recovery Implementation Task Force to help DMHSAS plan strategic changes in current psychosocial rehabilitation services that would slowly transform delivery of services across the state at the local level.

Progress during the past two years on this transformation effort includes the creation of a State Recovery Coordinator position, creation of a peer support specialist position to fully develop the Wisconsin model of peer specialists and development of a Recovery 101 curriculum that consumers, recruited and trained from across the state can teach at local agencies, drop-in centers and interested professional groups. A number of trainings have been delivered using consumers, including not only in community settings, but also at a women’s prison and some inpatient settings. In 2009, the Recovery training and technical assistance will continue. The DMHSAS will also continue to work with the Recovery Implementation Task Force to advise the Division on its work on promoting recovery.
Wisconsin

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

4. Recent Significant Achievements

Directions: A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Program of Assertive Community Treatment Research Project with Adolescents

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.

Transformation Achievements

DMHSAS began their transformation efforts with the hiring of a consumer affairs coordinator and the creation of a consumer run, statewide Recovery Implementation Task Force to help DMHSAS plan strategic changes in current psychosocial rehabilitation services that would slowly transform delivery of services across the state at the local level.

Progress in the last few years’ on this transformation effort includes the creation of a State Recovery Coordinator position, creation of a peer support specialist position to fully develop the Wisconsin model of peer specialists and development of a Recovery 101 curriculum that consumers, recruited and trained from across the state can teach at local agencies, drop-in centers...
and interested professional groups. A number of trainings have been delivered using consumers, including not only in community settings, but also at a women’s prison and some inpatient settings. Block grant funds have been used to fund Quality Improvement Projects in five pilot counties. Each county has implemented one of six Evidence-Based Practice Implementation Resource Kits from SAMSHA. The counties have utilized the fidelity scales to assure appropriate implementation and the Recovery Oriented Systems Indicators (ROSI) tool to assess consumer outcomes. Each county designed a specific QI project using data to identify an area of concern, make a change in practice, and measure improvement subsequent to the change. The transformation efforts also include development of peer specialists in Comprehensive Community Service (CCS) counties, development of training for local consumers on meaningful participation on the locally required CCS committees and the development of a manual for CCS that outlines the elements of strength based assessments, recovery based plans and consumer focused case noting that meets the Centers for Medicare and Medicaid Services (CMS) requirements.

In addition, through the mechanism of CCS*, DMHSAS is taking the lead in teaching counties how to use data in a meaningful way to drive continuous quality improvement, an additional requirement of the CCS rule. Additionally, the SAMHSA funded Data Infrastructure Grants (DIG) has provided Wisconsin with resources needed to develop the reporting capacity to meet the basic and developmental tables in the block grant requirements. Wisconsin has used the DIG resources to develop a data warehouse for combining Medicaid data with community mental health program data and to enable reporting on the basic and developmental tables required by the MHBG. The data is being integrated with the existing Medicaid data warehouse and will continue to be supported with the DIG.

*For More Information on CCS See Section "Available Services--Adults."

**Complimentary Funding for Inpatient/Outpatient and Psycho-Social Rehabilitation Services**

Starting in the fall of 2005, there has been a shift in focus in Wisconsin away from a proposed managed care model that includes behavioral health services that are beyond outpatient services, to an integrated model of services and supports that combines the Medicaid Health Management Organization (HMO) services that include both psychiatric inpatient and outpatient care with those psycho-social rehabilitation services provided by local county agencies. This complimentary system provides comprehensive physical health and mental health care for consumers who have needs beyond outpatient services. This shift in focus due to legislative action that ordered the expansion of SSI managed care statewide provided the opportunity for DMHSAS to focus on elements of transformation beyond the coordination of funding issues that dominated the previous redesign initiative.

**Recovery Oriented Systems Inventory (ROSI) Tool**

In 2007-2008 DMHSAS adopted the Recovery Oriented Systems Inventory (ROSI) tool as an additional tool for the CSP and CCS programs to use to assess their programs as they transition to person centered planning that is being implemented statewide through training and TA provided by national trainers. DMHSAS knew that in order to be able to measure transformation the state and local programs would need to increase their knowledge about what facilitates or hinders recovery from psychiatric disabilities, they would also need a core set of indicators to work with that measure elements of a recovery facilitating environment and be able to integrate that data into a system performance evaluation and quality improvement efforts, helping to generate comparable data across all systems. After much review it was decided by DMHSAS and their county partners that the ROSI tool had a great deal to offer in the way of solid data for a program
to assess if their service delivery system was consumer centered and recovery based, and it would fit with the WI mental health functional screen with complementary data.

Wisconsin intends to use ROSI as a transformation tool in the following ways: providing baseline data for current recovery orientation; identifying areas for QA/QI action plans; establishing benchmarks for targeted incremental progress; measuring general change over time; comparison of data across systems and programs; and finally data can be used to educate and sensitize the general public, human services boards and mental health professionals as well as consumers. With these goals in mind, DMHSAS staff with assistance from their data and evaluation expert from the UW Madison, designed an easy to use excel spread sheet that automatically sorts the data, scores the data and gives summaries in a variety of formulas so that local agencies can use it as a transformation tool in the ways outlined above. Training was given to all regions in the spring and summer of 2008, and county agencies are beginning to adopt it voluntarily.

A Mental Health/Substance Abuse (MH/SA) Functional Screen is in use to ensure the consistent screening of all consumers across the state for level of need. A web-based version of the MH/SA Functional Screen was developed and implemented in FFY 2005 as the screen began its roll out statewide. The screen is now being used in most counties to determine the need for psycho-social rehabilitation services beyond outpatient, and is utilized statewide for determining eligibility for the Community Options Program. Counties are being taught how to use the elements in the functional screen to identify indicators of progress on an annual basis, both on an individual level and at an aggregate level. The state is using the screen data to look at outcomes before and after individuals receive services.

Using the functional screen and encouraging the use of standardized consumer surveys, such as the Recovery Outcomes System Inventory (ROSI), will ensure that significant emphasis will be placed on the development of quality improvement systems during the next year.

Work continues on a number of transformation pilot activities that include developing a quality improvement (QI) process for Comprehensive Community Services (CCS) and Community Support Programs (CSP). 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 will be required to identify a Quality Team that steers their QI efforts, use the 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 were encouraged to use a standardized consumer survey such as the ROSI to identify systems issues around recovery. Marathon, Brown, Kenosha, Richland and Jefferson counties each received $59,000 grants for this purpose in 2008.

<table>
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<th>The transformation activities described above address: Goal 2, Recommendation 2.2; Goal 4, Recommendations 4.3 and 4.4; and Goal 5, Recommendations 5.1 and 5.2 of the President's Freedom Commission on Mental Health.</th>
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| **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.  
**Goal 4**—Early mental health screening, assessment, and referral to services are common practice.  
**Recommendation 4.3**—Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.  
**Recommendation 4.4**—Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports. |
Goal 5—Excellent mental health care is delivered and research is accelerated.

Recommendation 5.1—Accelerate research to promote recovery and resilience, and ultimately to cure and prevent severe mental illnesses.

Recommendation 5.2—Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

Newly-funded parts of the transformation initiative in FFY 2008 will include strategic planning with leadership from the Secretary of the Department of Health Services, with critical input from the Wisconsin Council on Mental Health and the Wisconsin Counties Association. Efforts will include a review of the current funding and responsibilities of the county-based system, as well as the Medicaid and Badger Care mental health and substance abuse service delivery system. The goal will be to increase access and streamline and improve outcomes of services to consumers.

Implementation of Evidence Based Practices

Marathon County

Marathon County was awarded MHBG funds from 2006-2008 to implement Integrated Dual Disorder Treatment (IDDT). In the first year of the initiative, consumers with dual diagnoses were identified through the use of a functional screen, a quality of life assessment, service facilitator reports and information provided by the North Central Health Care (NCHC) data department. Although some components of IDDT were in place at this time, full implementation of IDDT was not complete and consumer tracking/consumer outcome data was not collected on consumers specifically identified as dually diagnosed.

In 2006, staff participated in trainings necessary to implement IDDT such as substance abuse, quality improvement, front end ROSA (Recovery Oriented Systems Assessment), recovery, motivational interviewing, family psycho-education, transitions and grass roots empowerment education. In addition, training and education occurred in order to implement a Peer Specialists Program.

Pursuant to a baseline fidelity review completed in 2006, organizational changes and a baseline fidelity action plan occurred in order to outline necessary steps to reach and sustain high fidelity and improved outcomes.

Peer specialists/consumers have been involved since the initiative of the Quality Improvement Project. Their participation began with becoming part of the quality team and engaging in the Front End Rosa work that included the four other participating, the Bureau of Prevention Treatment and Recovery (BPTR), and The Management Group, Inc. (TMG). Eight consumers from Marathon County received over 30 hours of training through BPTR to work toward peer specialist certification. Since that time, peer specialists have become employed through NCHC, participated in trainings involved in the project, worked on both a warm line and on the inpatient unit at NCHC as well as participated as members of the inpatient committee. Peer Specialist work over the past three years has also included providing one on one service activities with other consumers, administering ROSI (Recovery Oriented Systems Indicators Tool) and quality of life surveys and educating staff, families and consumers individually and in a group setting.

The primary accomplishments in 2006 include stakeholder education in the IDDT model and recovery principals, training and implementation of a Peer Specialist Program, as well as further initiation of system transformation in terms of recovery principals and philosophy.
In 2007, 98 additional consumers were identified as having co-occurring mental health and substance abuse disorders and were eligible for IDDT services. However, only 59 consumers chose to participate in IDDT services.

The primary accomplishment of 2007 was that the Tri-County QI Project team was engaged in the action phase of implementing IDDT which included developing and monitoring outcomes of all consumers identified as having co-occurring disorders. Line staff, consumers, peer specialists and supervisors were trained in order to ensure providers were knowledgeable in motivational interviewing, stages of change and substance abuse. Peer Specialists in their own recovery became integral members of the multidisciplinary team. Additionally, one staff was certified as a substance abuse Clinical Supervisor and opportunities were made available for line staff to work toward substance abuse certification thus increasing the availability of integrated services for consumers. The implementation of Psycho-Education classes facilitated by peer specialists occurred twice throughout the year. Overall, outcomes improved for consumers identified with co-occurring disorders.

In 2008, 15 additional consumers participated in IDDT treatment. Person Centered Planning was incorporated into Integrated Dual Disorder Treatment thus allowing for the possibility of more achievable goals for consumers. Consumers individually or with the assistance of recovery team members outlined objectives that were obtainable and achievable resulting in success of desired outcomes. Overall, consumers reported feeling empowered not only in the process of identifying their own goals and steps towards achieving those goals but as meaningful participants in their own recovery.

Accomplishments in 2008 included:
- Full implementation of Integrated Dual Disorder Treatment in Comprehensive Community Services (CCS) Programs.
- Peer Specialists providing warm line services.
- A Peer Specialist on the inpatient unit.
- Peer Specialists on individual recovery teams.
- The use of Peer Specialists in data collection.
- Initiation of Peer Specialists completing WRAP with consumers.
- Data driven quality improvement projects.
- Person Centered Plans fully implemented in CCS.
- Graduated student internship in the Peer Specialist Program.

**Brown County**

Brown County began the first year of their MHBG funded initiative working toward implementation of Integrated Dual Diagnosis Treatment (IDDT) across all programs, including Comprehensive Community Services (CCS) and Community Support Programs (CSP), and to also include their contracted agencies in the community. Fifty-six individuals identified as having co-occurring disorders received integrated services in 2006. This was primarily through the use of a part time dually certified therapist. A QI committee consisting of consumers, staff from mental health and substance abuse areas, including CCS and CSP, was established. The committee was combined with the CCS coordinating committee and held regular meetings. A two day Motivational Interviewing training was provided to staff through the University of Wisconsin Milwaukee. Focus groups were also held at a variety of locations to receive feedback from consumers, staff, community members and agencies on areas that could be addressed. Finally, a nationally known expert on co-occurring contracted through ZIA, Inc. provided
assistance on implementing IDDT. During 2007, ZIA staff provided a series of trainings and meetings for the project.

Brown County also received data grant funding during 2007 and worked to identify and improve their data resources. A data staff person had been hired by the department who was skilled in using the existing system utilized by the Human Services Department. The grant allowed the project to obtain the software needed to generate reports that will be used by their department to help with tracking progress on outcomes. These reports have allowed staff to implement better quality control of the data and to collect additional data because of increased capacity to store data. Additionally in 2007, sixty-seven individuals were identified in the system as receiving co-occurring services from their part time dually certified therapist.

In 2008, the dual diagnosis team was comprised of all of the substance abuse staff and four mental health staff persons. They had two staff and two supervisors who were dually licensed in mental health and substance abuse, and another staff member working toward substance abuse licensing. During the year, 65 consumers received dual diagnosis services. Consumers are assessed at admission on whether co-occurring issues exist and then assignment is based with this information in mind. Part of the grant was used to modify the county website to provide access to trainings that will be posted on line for staff and providers.

**Richland County**
Richland County reported on 2008 results of its MHBG funded evidence based practice (EBP) initiative. Measurable outcomes for this year of the initiative included:

- Implemented Person Centered Treatment Planning in CSP and CCS programs.
- Implemented Evidence Based Practice: Illness Management and Recovery.
  1. Completed Illness Management and Recovery curriculum for two groups totaling 12 consumers.
  2. Completed General Organizational Index and Fidelity Scale for EBP.
  3. Regular data collection on quarterly outcomes for EBP
- Conducted first Quality of Life Self Assessment Survey with consumers of CSP and CCS.
- Conducted second year of Recovery Oriented Systems Indicators (ROSI) surveys with consumers of CSP and CCS.
- Conducted Quality Improvement Project using the Best Clinical Administrative Practices (BCAP) typology to increase consumer satisfaction levels with their participation in community activities (leisure, social life, spiritual life, volunteer work, etc.)
- Conducted regular meetings of Quality Team to review data and recommend quality improvement activities.

**Jefferson County**
Jefferson County reported that in 2008 it utilized MHBG funds to implement three EBPs: Illness Management and Recovery; Supported Employment; and Seeking Safety. Five consumers received Illness Management and Recovery services, 20 consumers received Seeking Safety services, and 33 consumers received Supported Employment services.

The initiative incorporated the principles of Person Centered Planning into the implementation of the EBPs. Staff reported that Person Centered Planning helped consumers and staff better identify what they wanted to set as goals and objectives. More people seemed to actively
participate in their service selections and recovery plans. More people appeared to be interested in working and in available treatment options.

Staff reported that a primary accomplishment in 2008 was the success of Seeking Safety, an integrated dual diagnosis treatment for post traumatic stress disorder (PTSD) and substance abuse. Participants reported that the information and skill building are extremely valuable and that their trauma is being treated for the first time ever. Additionally, people reported being able to manage their substance abuse issues better. Another accomplishment was an increased fidelity to the Supported employment model and an increased number of people working in a job of their choosing.

**Kenosha County**

Kenosha received three years of MHBG to implement the EBP "Wellness Management and Recovery." The initiative served 15 consumers in year two and 25 additional consumers in year three. The project reported that the Person Centered Planning training had a significant impact on the EBP since it complimented the consumer's recovery and wellness planning. Person Centered Planning focuses on strength-based and consumer-driven approaches similar to the Wellness Management and Recovery approach.

Project staff reported that the primary accomplishment of the initiative was sustaining the EBP program. They report that the program is embedded in the Comprehensive Community Services program and all peer support specialists completed EBP training. Each participant and peer support specialist received formal recognition in the quarterly Coordination Committee meetings by their receipt of both an engraved medallion and a certificate of completion of the EBP program. Additionally, the Quality Team and Committee recommended supporting the Service Director's initiative to formally train all six peer support specialist in Wellness Management and Recovery. It is the intent of the Coordination Committee and Quality Team to promote and utilize peer support specialist as co-facilitators in EBP groups under supervision of the Service Director.
Wisconsin

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

5. State's Vision for the Future

Directions: A brief description of the comprehensive community-based public mental health system that the state envisions for the future.

Wisconsin's Vision for the Future

Wisconsin's plan for its comprehensive community-based mental health system has many similarities to the goals of the President's New Freedom Commission on Mental Health (NFC) established in 2003. The six primary goals of the NFC include:

1. Americans understand that mental health is essential to overall health,
2. Mental health care is consumer and family driven,
3. Disparities in mental health services are eliminated,
4. Early mental health screening, assessment, and referral to services are common practice,
5. Excellent mental health care is delivered and research is accelerated, and
6. Technology is used to access mental health care and information.

Wisconsin's Mental Health system transformation efforts including Comprehensive Community Services (CCS) initiative in the adult system and the Coordinated Service Team (CST) and Integrated Services Projects (ISP) initiatives in the children's system all incorporate the NFC's vision and goals 2, 4, 5 and 6.

Wisconsin has an established goal for its mental health system:

“All persons in need of mental health services across Wisconsin have access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity.”

The ideal service system will target prevention, early intervention, treatment, recovery, consumer and family involvement and participation, consumer and family-centered service delivery, a culturally competent workforce and services, and reduction of stigma.

Transformation Activities

In step with the goals of the NFC, Wisconsin's plans to continue its prioritization of implementing system transformation and promote recovery-based services development in FFY 2010. Currently, Wisconsin is developing a model of services and supports that braids together the Medicaid Health Management Organization (HMO) services that include both psychiatric inpatient and outpatient care with those psycho-social rehabilitation services provided by local county agencies. This complementary funding provides comprehensive physical health and mental health care for consumers who have needs beyond outpatient services. This shift in focus due to legislative action that ordered the expansion of SSI managed care statewide provided the opportunity for DMHSAS to focus on elements of transformation beyond the coordination of funding issues that dominated the previous redesign initiative.

Newly-funded parts of the transformation initiative in FFY 2010 will implement results of the strategic planning for the local public mental health system. Efforts may include the current
funding and responsibilities of the county-based system, as well as the Medicaid and BadgerCare mental health and substance abuse service delivery system. The goal will be to increase access and streamline and improve outcomes of services to consumers.

**Objective:** Transform the Wisconsin Public Mental Health system into an integrated model of services and supports that braids multiple funding sources.

**Recovery Activities**

DMHSAS has augmented their transformation efforts with the hiring of a consumer affairs coordinator and the creation of a consumer run, statewide Recovery Implementation Task Force to help DMHSAS plan strategic changes in current psychosocial rehabilitation services that would transform delivery of services across the state at the local level.

Wisconsin increased the allocation of the Mental Health Block Grant (MHBG) to Family/Consumer Self-Help and Peer to Peer Support Programs from $874,000 to $991,629 annually in 2008 and 2009. The level will stay the same in 2010. While some other states do not directly fund peer support services, Wisconsin set aside 13.4 percent of its MHBG for this purpose. Wisconsin will continue to fund consumer recovery and peer support programs with the same aggregate level of funding. Wisconsin funds a variety of consumer recovery and peer support programs including programs that work with adult consumers, child consumers, and families of consumers.

**Person Centered Planning/Trauma Informed Care Champions**

The Bureau of Prevention Treatment and Recovery (BPTR) received two federal grants in 2009, for Person Centered Planning and Transformation Transfer Initiative (trauma informed care). BPTR has an assigned team of staff and contractors internally to work on various aspects of the implementation of these projects. In addition, the Bureau will obtain continuous input and feedback from community stakeholders, including counties, advocates, family members, and facilitate meaningful participation of consumers.

The Bureau Comprehensive Community Services (CCS) coordinator will lead the Person Centered Planning initiative, which is funded through the Center for Medicare and Medicaid Services. The initiative will provide training, consultation and technical assistance to counties, providers and consumers on implementing this initiative.

The Bureau Trauma Coordinator will lead the Trauma Informed Care Initiative, which will be funded through the National Association of State Mental Health Program Director's (NASMHPD). This project is training and supporting a cadre of Trauma Champions across the state to infuse trauma informed care principles into mental health systems of care, as well as policy documents, training materials and treatment approaches.

The Consumer Affairs Unit within BPTR has created a statewide pool of consumer peer co-trainers known as "Person Centered Planning/Trauma Informed Care Champions." Person centered planning and trauma informed care principles are essential building blocks in creating an environment that supports recovery for individuals. Eighteen individuals have been chosen through an application process based on their understanding of recovery and trauma, demonstrated skills, prior training, and availability for participation in statewide coverage. Expectations of the chosen partners include participation in the following activities:
• A 15-hour "Train-the-Trainers" event on April 22 through 23, 2009 in Stevens Point, Wisconsin to learn how to present a one-day training for consumers: "A Recovery Approach to Person Centered Planning."
• A one-day national overview of person centered planning on April 28, 2009, in Madison, Wisconsin.
• A two-day "Creating Trauma Informed Systems of Care" conference on May 11 through 12, 2009, in Wisconsin Dells.
• Attend and co-present at a minimum of two regional trainings in 2009.
• Be an Ambassador for Recovery, utilizing the principles of person centered planning and trauma informed care.
• Attend a one-day "Support Retreat" to review progress of the initiative in the late summer of 2009.

Objective: Expand funding for consumer and family programs and services in 2009.

Hiring of a Trauma Coordinator*

A trauma Coordinator was hired by the University of Wisconsin-Madison in partnership with DMHSAS in April of 2008. She is responsible for collaborating with consumers and other mental health and substance abuse systems' stakeholders in the planning, development and implementation of trauma informed care in community based mental health, substance abuse and other human service settings. In addition to increasing trauma-related awareness in the services community, this initiative will improve mental health and substance abuse services to people impacted by trauma.

*For Details on Trauma Prevention Activities See Section "Available Services Adults."

Evidence-Based Practices

Another essential step to implementing the goals of the NFC is Wisconsin's plan to assess and implement evidence-based practices (EBP) for adults and children. The transformation efforts include the fostering of evidence-based practices in pilot counties (currently 5 counties are participating).

In FFY 2008, there are 78 Community Support Programs (CSP) 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. CSPs are based on the Assertive Community Treatment (ACT) model.

Evidence Based Practices Pilots

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. Three counties are implementing IDDT and two counties are implementing IMR. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation.

Evidence-Based Program grants will also be awarded in 2009 to help counties continue their implementation and quality improvement work. 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.*

*For more information on EBPs see Adult Section on "Recent Significant Achievements."

**Serving Older Adults with Severe Mental Illness**

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 done by staff at DMHSAS. An important component of the DMHSAS planning work is the development of the Wisconsin Gero-psychiatry Initiative (WGPI). The WGPI began as a collaborative of community stakeholders interested in making gero-psychiatric expertise available to providers 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 gero-psychiatrists 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 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 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 severe 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 has set aside money for continued outreach and training in the 2010 plan, and will team 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 need treatment but have never been diagnosed or treated for their severe mental illness because of stigma and self isolation.

**Additional Efforts to Address Older Adults**

The Division’s efforts in providing services to older adults is multi-faceted. The single largest source of funding in the community for Wisconsin older adults is the new long term care managed care program, Family Care. In order to access these services, Wisconsin older adults need to have physical conditions that need nursing management, or functional deficits that require assistance to perform basic activities of daily living. Approximately 55 percent of people enrolled in this long term care program have mental health diagnoses. The Division has been working on several levels with the Family Care program. The Division has provided several trainings and technical assistance events to the Aging and Disability Resource Centers, to allow them to perform intake and referral to people with severe mental illness seeking services. The Division has provided training at the MCO level for nurses and social workers in person centered planning for people with physical and mental health issues, has provided systems level assistance to the Division of Long Term Care staff on program development for specialized programs for people with mental health and substance abuse issues, and most recently has taken the lead in writing a grant to SAMHSA to improve services to older adults in conjunction with primary care physicians. One part-time person at the division level is dedicated to providing technical assistance to collaborating agencies that provide services to older adults with mental health issues. At the Division level, the key staff from Family Care and the key community care
program staff from DMHSAS meet to identify program and service delivery issues and engage in collaboration efforts to improve service delivery within the Departments contracted managed care organizations.

**Objective:** To improve outreach to rural isolated elderly persons with severe mental illness.

**Division of Vocational Rehabilitation (DVR) Activities to Increase Employment for Mental Health Consumers**

The Department of Workforce Development (DWD), as the primary agency responsible for employment services, has received funds from the Recovery and Reinvestment Act. Guidelines for the use of these funds have not yet been received for all Divisions. DVR anticipates receiving approximately ten million dollars to be spent within two years. Fifty percent of these dollars are expected to be available by the end of March 2009. Guidelines for use have not been received, but DVR is planning to utilize Recovery and Reinvestment funds to make DVR services available to more consumers who have been waitlisted, and to possibly provide employment to individuals who will provide vocational rehabilitation services.

In January 2009, DVR had sufficient funding to invest in employment plan services for an average of 12,373 individuals on a daily basis. At the end of February 2009, DVR had more than 64,000 eligible applicants wait-listed for vocational services. By July 2010, the Division projects an increase in caseload from the current level of 12,400 to a daily average service capacity of 14,656 individuals. This is an increase of more than 2,250 individuals a day receiving vocational services.

DVR’s purpose is to assist all persons with disabilities regardless of the type of disability to achieve their employment goals by removing barriers to their full employment. With this additional federal support, DVR will be able to provide employment services to people who would otherwise need to remain on a wait-list for much longer.

**Objective:** To increase employment opportunities for mental health consumers.
Wisconsin

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

1. Service System's Strengths and Weaknesses

Directions: A discussion of the strengths and weaknesses of the service system.

Integrated System of Care

STRENGTHS IN THE CHILDREN'S SYSTEM

Information regarding strengths in the children's public mental health system 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

*Wisconsin is working to expand mental health services to better address consumers needs.*

The primary issue to be addressed regarding the epidemiology of mental health disorders in Wisconsin is increasing the availability of mental health services to more closely match the need within the state. The strengths in this area are the State's and counties' ongoing efforts to increase services available to consumers such as the creation of CCS. Wisconsin is always trying to increase the number of evidence-based mental health programs and services available in the state to serve more consumers.

The DMHSAS estimates that there are 89,971 children with SED between the ages of five and 17. In 2002, the Census Bureau estimated Wisconsin’s poverty rate for children 17 and under in 2002 was 10.9 percent. The national poverty rate for the same population was 16.7 percent. As Wisconsin is more than five percent below the national poverty level, the lower percent range is used for our prevalence estimates, as recommended by CMHS. Not all of these children will require specialized services nor do they need ISP level of service delivery. Some children can be served through outpatient services provided in the mental health and social services system. According to the 2007 Wisconsin Family Health Survey, it is estimated that approximately 64,000 children (five percent of the 1,293,000 children in the state) were uninsured for part or all of 2007. Eight percent of children living in poor households (10,000) and 10 percent of children living in near-poor households (23,000) had no health insurance during part or all of 2007. This contrasts with three percent of children living in non-poor households (29,000) who had no insurance during part or all of 2007.
2. Provider Capacity

*Wisconsin's goal for children's mental health services includes using a wraparound approach to service delivery.*

The vision for Wisconsin's children's mental health system is best embodied in its current CST Initiative which uses a wraparound approach to service delivery. The wraparound approach is an evidence-based practice. The goal is:

“To implement a practice change and system transformation in Wisconsin by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families who require substance abuse, mental health, and child welfare services.”

The ideal would be that the children’s mental health system would have a wraparound service delivery system in every county. Important components of the CST vision that fit with the New Freedom Commission on Mental Health goals include the emphasis on consumer and family-driven services (Goal 2 of the NFC). One of the CST goals is the individualization of treatment plans with child and parent involvement in the planning process. Service plans and treatment delivered through CSTs are designed in a culturally competent manner (Goal 3). Screening for co-occurring disorders and the integration of the mental health system with school systems, the juvenile justice system and primary care are also central tenets of the CST Initiative (Goal 4). The use of the wraparound service delivery approach illustrates how CSTs are using some of the best practices available (Goal 5). In accordance with Goal 6, Wisconsin will continue to promote and expand the use of tele-health technology particularly to promote access to child psychiatry in rural areas of the state.

*The Comprehensive Community Services (CCS) initiative serves children with SED as well as adults with mental illness. This initiative is integral to transformation of the state's mental health system as it expands access for both children and adults.*

As mentioned above, the addition of CCS to Wisconsin's service continuum is a significant improvement not only for adults but children as well. CCS will provide an important new set of services to children with severe emotional disorders (SED) and will make them financially accessible since certified county providers will be able to bill Medicaid for CCS.*

*For More Information on CCS, See Section "Available Services--Adults"*

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*
The child welfare system partnerships with wraparound system of care development.

At the state level in 2002, the Division of Children and Families and the Division of Mental Health and Substance Abuse Services endorsed a joint letter to support the Coordinated Services Teams (CST) core values in a wraparound approach to serving children with multiple and complex needs. Since then, the CST program has integrated child welfare workers into their wraparound teams to coordinate mental health and other needed services with services provided through the child welfare system.

Wisconsin has passed a law requiring that law enforcement include mental health clinicians in all emergency detentions to State Mental Health Institutions.

The 2009-2011 biennial budget requires that law enforcement personnel consult with county mental health crisis staff prior to doing an emergency detention. In the past language had been crafted in Chapter 51 to that effect, but had not been effective in enforcing this policy statewide. "Best Practices" were developed also several years ago which required mental health/crisis staff to be involved with Law Enforcement any time that an emergency detention was being considered. In many counties there had been improvement in this area, resulting in a decrease in emergency detentions and hospital admissions. The new budget requires that all counties adopt and enforce this policy.

3. Funding

Wisconsin will utilize its Data Infrastructure funds to collect better data on evidence-based practices.

In FFY 2008, Wisconsin continued to work towards the implementation of new evidence-based practices. Wisconsin submitted its new Data Infrastructure Grant application for FFY 2008 with plans to collect data on the use of evidence-based practices. Counties were surveyed through the use of a web survey tool about the evidence-based practices they currently use. Funding from the Data Infrastructure Grant will be used when possible and supplemented with Mental Health Block Grant funds if necessary, but cost will be minimized to staff time because the web survey tool was purchased previously. The survey is helping begin the process of defining evidence-based practices (EBPs) for counties as well as yield data on current use and future needs for EBP.

4. Data

Wisconsin has created a mental health data warehouse with merged HSRS and Medicaid data.

One of Wisconsin's strengths in both the adult and child systems is its efforts to merge county-based HSRS mental health consumer data with the state Medicaid data in a data warehouse. The top priority for data integration is linking the HSRS mental health and substance abuse (MH/SA) data with the Medicaid MH/SA data. The HSRS mental health and substance abuse data is currently linked and available for analysis in the data warehouse. In addition, the Medicaid MH/SA data is now available for analysis in the data warehouse and has also been linked to the
HSRS MH/SA data. Mental health and substance abuse staff in the DMHSAS are now accessing this data for analysis and report writing.

WEAKNESSES IN THE CHILDREN'S SYSTEM

Information regarding weaknesses in the children's public mental health system 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

The child welfare system does not adequately address mental health issues.

A federal review was conducted of Wisconsin's child welfare system which revealed insufficient efforts to address the mental health needs of children including a lack of consistency in providing mental health assessment services and too few mental health providers to meet the needs of children in the child welfare system. As a result, the State's child welfare agency is implementing a Program Enhancement Plan that identifies a strategy to work with children's mental health and tribal child welfare agencies to develop a statewide policy for the screening and assessment of the mental health needs of children who have been abused or neglected, and to develop a capacity improvement plan for mental health screening, assessment, and treatment.

Services for children with significant emotional problems, but who are not involved in two or more systems are lacking.

Wraparound systems of care for children in Wisconsin are designed to serve children who are either severely emotionally disturbed, or who have mental health issues and are not necessarily SED, but are involved in two or more systems. There is a large population of children who have mental health issues, but do not fulfill the criteria for enrollment into the wraparound system of care. Without early intervention, it is likely that these children and their families will experience a worsening of their symptoms, resulting in increased problems at home and in the community. This population needs to be fully identified and the magnitude of the problem assessed. Based on this needs assessment, a plan to address it should be developed and implemented in the state. The role of Family Advocates in supporting these families needs to be investigated also.

2. Provider Capacity

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 programs. Thus, the system is difficult to navigate for consumers because of its complexity. Opportunities for leadership in planning collaborative initiatives and facilitating collaboration among local providers still exist. CCS will be an opportunity to begin collaborative efforts with the ability to fund integrated mental health and substance abuse treatment.
There is a shortage of Child and Adolescent Psychiatrists in Wisconsin.

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 disorder. According to 2006 a report by Thomas and Holzer, Wisconsin, while near the average, was still one of 35 states with less than the national average of 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.

There is a shortage of Medicaid dental providers that will serve mental health consumers.

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 HMOs which cover dental services in order to increase access to those services. Dentists continue to lobby for increased Medicaid reimbursement rates. 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 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 who on 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.

3. Funding

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 Joint Finance 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 a 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. A companion bill was introduced in the Assembly late in the session. The session ended before this bill could be acted on.

Parity has been enacted on the federal level. It is unclear how this will affect Wisconsin's mental health coverage.
There are unbalanced Medicaid incentives to institutionalize children in Wisconsin.

In Wisconsin, Medicaid pays the majority of stays at a state mental health institution for children aged 21 and under. Thus, the county has a financial incentive to admit children for inpatient psychiatric services that will be paid for by Medicaid. Additionally, there is the potential for counties to have their budgeted funds for treating children with SED completely expended for a few high cost individuals. Particularly children who have SED with significant behavioral challenges can be very high cost. For example, one or two high-cost consumers at residential treatment centers have the potential to utilize the entire budget, especially for smaller counties. This adds to the incentive to place them in a hospital setting.

The new 2010-2011 biennial budget requires that counties pay the state share on costs for state mental health institute stays for individuals under age 22 and over age 64. The administration estimates GPR savings at approximately $8 million, annually. This will provide a disincentive for inpatient services in the state mental health institutes. The new budget also provides $1 million new GPR funding for 2010 and $3 million new GPR for 2011 for certified community mental health services, including CCS, CSP or crisis services.

4. Data

Wisconsin Mental Health Council has concerns with the Human Services Reporting System data.

Council members are concerned about the quality and sources of data collected by the Department of Health Services (DHS). These concerns are particularly acute with respect to report of services by counties which determines 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 states that their recommendations are unfortunately undercut by inadequacies in both. They state that they are pleased that the Department is committed to continue work to improve its data systems and quality. With the Data Infrastructure Grant, the Department is working toward and encounter-based system and the eventual retirement of the 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.

Data on the magnitude of underserved children aged 0-5 needing mental health services in Wisconsin is lacking.

As most infants and young children with mental health and/or social-emotional/developmental issues come into contact with many types of healthcare providers and other childhood workers who are not in the mental health field, it is difficult to assess the availability of services that specifically address this population. Without existing credentialed infant mental health providers
and consistent billing for infant mental health/emotional development services through Medicaid, it is very difficult to track the number of providers and services being provided specifically to address this population. Although the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) is currently being implemented in Wisconsin, providers are not consistently billing for Medicaid services through this new system.

Wisconsin is currently working hard to address these issues by further educating pertinent stakeholders on the implementation of DC:0-3R, and adopting the Michigan Endorsement Process to increase the infant mental health workforce in the state.

5. Stigma

Stigma is an ongoing problem for children with severe emotional disturbances.

The long term goal is the elimination of stigma and discrimination associated with severe emotional disturbance (SED) in Wisconsin. Children with SED and their families are impacted by the prevalence of stigmatizing beliefs and attitudes as well as systemic and environmental barriers and disincentives. Improved acceptance will be achieved in the following areas for children, youth, adults and older adults, families, and veterans when:

- Mental health consumers and children with SED 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 mental illnesses, that such mental health consumers are more dangerous than others through factual information and accurate media reporting; 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 mental illness diagnoses and struggles private.
Wisconsin

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
Section II - Identification and Analysis of the Service System's Strengths Needs and Priorities

2. Unmet Service Needs

Directions: An analysis of the unmet service needs and critical gaps within the current system and identification of the source of data which was used to identify them.

1. Access to Services and Provider Capacity

Access to children's mental health services needs to be improved in the state.

Access for children to mental health services in Wisconsin is an issue. Although many counties have integrated services projects, many do not and those that do serve children that are involved in more than one system and are "deeper end" youth. Additionally, most of the integrated systems of care limit services by age and usually do not serve very young children. CSPs generally do not accept teens, therefore youth with serious emotional disturbance are not able to access programs that offer the level of support they need (Dane County is an exception).

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 disorder. According to 2006 a report by Thomas and Holzer, 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.

Additionally, Pediatricians are frequently the providers of psychotropic meds and have no specialized training. Also, Medical Assistance does not pay for doctor-to-doctor consultation, therefore Pediatricians cannot bill time to consult with psychiatrists. Additionally, Tele-psychiatry is unavailable and/or underutilized for youth with serious emotional disturbance. Providers report that Medicaid reimbursement is too low and there is a lack of parity for mental health services.

Transitional services for youth aging out of children's mental health programs is lacking.

A gap in the current continuum of mental health care in Wisconsin is transitional mental health services for youth aging out of the children's system and not yet old enough to receive services through the adult system. These youth often fall through the cracks, ending up in the juvenile justice or adult corrections system or homeless because they do not receive the mental health care they need to remain stable in the community. Wisconsin is working on a transitional services initiative to address this problem.*

*See Section "Plans to Address Unmet Needs--Children" for Information on Transitional Services for Youth in Wisconsin.
The children's welfare system does not adequately address children with mental health and trauma issues.

A federal review was conducted of Wisconsin's child welfare system which revealed insufficient efforts to address the mental health needs of children including a lack of consistency in providing mental health assessment services and too few mental health providers to meet the needs of children in the child welfare system. As a result, the State's child welfare agency is implementing a Program Enhancement Plan that identifies a strategy to work with children's mental health and tribal child welfare agencies to develop a statewide policy for the screening and assessment of the mental health needs of children who have been abused or neglected, and to develop a capacity improvement plan for mental health screening, assessment, and treatment.

There exists a shortage of Medicaid dental providers that serve children with serious emotional disturbances.

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. Often in Wisconsin, dentists simply state that they are not taking on any new Medicaid patients. Dental care services were given increased focus during recent contract negotiations with certain HMOs which cover dental services in order to increase access to those services, but it continues to be a significant problem both in Medicaid HMOs and fee-for-service providers. Dentists continue to lobby for increased Medicaid reimbursement rates. For children/youth that have 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 who on 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.

2. Funding

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 Joint Finance 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 a 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. A companion bill was introduced in the Assembly late in the session. The session ended before this bill could be acted on.
Parity has been enacted on the federal level. It is unclear how this will affect Wisconsin's mental health coverage.

3. Data

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

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.
Wisconsin

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

3. **Plans to Address Unmet Needs**

**Directions:** A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Mental Health Needs for Children

1. **Access to Services**

*Access to psychiatrists/psychologists for children and adolescents will improve in the state.*

**Child Psychiatrists May Now Bill for Relational and Developmental Therapy with Children Aged 0-4**

**Background**

The original *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3) (ZERO TO THREE, 1994) was designed to address the need for a systematic, developmentally based approach to classification of mental health and developmental difficulties in the first three years of life. Recognizing that early care giving relationships are critical to infants' mental health, and that the rapidity of early development critically influences assessment, diagnosis and treatment, the DC: 0-3 manual addresses the unique mental health and developmental issues of very young children. The manual is philosophically based in a relational, family-centered approach that supports the child while diagnosing the symptoms. DC: 0-3 identifies and describes disorders not addressed in DSM or other mental health classification systems and provides professionals a guide to diagnose, prevent and treat difficulties in the earliest years. In 2005, a revised edition was released and is now commonly referred to as DC: 0-3R. The revised manual clarifies diagnostic criteria and offers checklists and observation guides to assist the diagnostic process.

**Implementation of DC: 0-3R in Wisconsin**

The Department of Health Services Infant Mental Health Leadership group has identified the use of the DC: 0-3R as a priority for mental health clinicians providing treatment to children under the age of four. Few mental health clinicians receive training in working with infants in their graduate school programs and as a result, in-service training is required to build the knowledge and skills needed to effectively provide clinical interventions with this population. Training in the use of DC: 0-3R is one step in building the needed knowledge and competencies. Monies have been allocated to conduct a statewide training of practitioners as well as to develop a cadre of state DC: 0-3R trainers.

ZERO TO THREE (ZTT) spearheaded the development of the DC: 0-3 and the revised manual, and is its publisher. A group of national ZTT DC: 0-3R trainers have developed the approach to training practitioners and trainers and have trained thousands of mental health professionals nationwide and overseas. This group meets regularly to maintain skills, build knowledge and to
continuously improve the training. Wisconsin Alliance for Infant Mental Health (WI-AIMH) contracted with ZTT to provide practitioner preparation on the clinical use of DC: 0-3R as well as a year long training of trainers program.

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

**DC 0-3R Training: Madison, Wisconsin**

WI-AIMH held the first state wide training on the DC: 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised) on September 15-17, 2008 in Madison, Wisconsin. The first day “Awareness Training” was a half day session that introduced infant and early childhood professionals to the concepts, principles, practices and theories of infant mental health. An overview of DC 0-3R as an approach to understanding and diagnosing disorders of early childhood was also provided. Over 60 professionals attended this session including representatives from Birth to Three (Part C), mental health, child welfare, and home visiting programs.

On September 16-17, 2008 the “Practitioner Preparation Training” was held. This training was designed for licensed mental health practitioners who are able to diagnose. Key concepts in infant mental health were reviewed and the development, philosophy and use of DC: 0-3R was highlighted. In small group discussions, participants applied clinical reasoning and diagnostic thinking to case studies and used the Decision Guidelines to experience the diagnostic process. Over 25 mental health practitioners from a variety of disciplines, including social work, psychology, marriage and family therapy and counselors attended these sessions. Six clinicians were chosen to participate in the train the trainers program. Monthly consultations for a year with the national trainer will be provided for those in the train the trainers programs. Additionally, the participants of the “Practitioner Preparation Training” have been invited to attend the monthly consultations to further their own understanding of the diagnostic process.

Based on both the evaluations received and verbal feedback, this was an excellent and useful training for those who attended. Early childhood professionals now have an overview of the diagnostic tool used for infants, toddlers and young children and will be able to use the same language and understanding when collaborating across disciplines. Additionally, mental health practitioners appear eager to continue learning more about assessment, diagnosis and treatment of infants, toddlers and young children. This training was repeated in March 2009 in Eau Claire and in September 2009 in Wausau.

**Infant and Early Childhood Mental Health Conference**

On June 18-20, 2008, Wisconsin Alliance for Infant Mental Health hosted its first statewide conference, “Early Relationships Matter: Building Networks.” More than 375 people attended the three-day event at the Concourse Hotel in Madison, Wisconsin, including representatives from 49 Wisconsin counties, and the states of California, New Mexico, Illinois, New Jersey, Arkansas, Minnesota and Tennessee. The conference featured three internationally-known and respected keynote speakers in addition to 39 workshops covering infant and early childhood mental health, the importance of early relationships, brain development, attachment, sensory integration, temperament and a variety of other topics. June 18th consisted of a pre-day conference with three different seven hour sessions, of which over 150 people attended. Reggie Bicha, secretary of the
new Department of Children and Families, gave enthusiastic and inspirational opening remarks. A free parent event was held during the evening on June 19th. Bestselling author and parent educator Mary Sheedy Kurcinka shared her insights, knowledge and expertise in the area of child temperament with both parents and professionals. The feedback on the conference was very positive and another conference is planned for 2009.

**Transitional services for youth aging out of children's mental health programs are being addressed.**

The Mental Health Transition Advisory Council (MHTAC) has been in existence since 1999. MHTAC has developed a statewide plan and action steps have been developed and updated to improve the transition of youth with SED to the adult mental health services they may need and the highest level of independent living they are capable of attaining. MHTAC members represent a coalition of parents, several Departments, Divisions, advocacy agencies, and adolescent and adult programs in several counties.

The group has worked in several areas, including the encouragement and funding of county-based transition events; collaboration with Independent Living Coordinators serving youth in foster care; provision of materials and presentations at conferences; and provision of scholarship awards to UW-Whitewater’s transition camp. Hundreds of copies of pamphlets of the MHTAC, primarily “Transition Resources for Adolescents with Mental and/or Emotional Disorders and Their Families,” “Do It Yourself Case Management,” and a transition flowchart have been distributed statewide to family members, providers, program administrators, teachers, and other key stakeholders. All information is also available electronically on the web.*

*For More Information on Transitional Services for Youth, See Section "Available Services--Children."

**Wisconsin is working on increasing the number of Medicaid funded dental providers that will serve children with SED.**

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 people would be unable to receive essential services or would receive uncompensated care. Medicaid continues to try to raise provider reimbursement rates, but is required to work within State budget constraints.

**Wisconsin is working on improving access for children's mental health services.**

Wisconsin's goal for children's mental health services includes using a wraparound approach to service delivery.

The vision for Wisconsin's children's mental health system is best embodied in its current CST Initiative which uses a wraparound approach to service delivery. The wraparound approach is an evidence-based practice. The goal is:

“To implement a practice change and system transformation in Wisconsin by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families who require substance abuse, mental health, and child welfare services.”
The ideal would be that the children’s mental health system would have a wraparound service delivery system in every county. Important components of the CST vision that fit with the NFC goals include the emphasis on consumer and family-focused services (Goal 2 of the NFC). One of the CST goals is the individualization of treatment plans with child and parent involvement in the planning process. Service plans and treatment delivered through CSTs are designed in a culturally competent manner (Goal 3). Screening for co-occurring disorders and the integration of the mental health system with school systems, the juvenile justice system and primary care are also central tenets of the CST Initiative (Goal 4). The use of the wraparound service delivery approach illustrates how CSTs are using some of the best practices available (Goal 5). In accordance with Goal 6, Wisconsin will continue to promote and expand the use of tele-health technology particularly to promote access to child psychiatry in rural areas of the state.

Wisconsin continues to work annually to expand the number of counties and tribes that have a Coordinated Service Team (CST) in order to reach the goal of eventually having CST projects available 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.

*For More Information on CST, See Section "Available Services--Children."

Significant achievements have occurred in FFY 2008 in the continuing development of comprehensive community-based mental health systems for children and adults in Wisconsin. One of the most significant achievements has been the ongoing implementation and expansion of a Medicaid-reimbursable service to Wisconsin's continuum called the Comprehensive Community Services benefit for both children and adults across the lifespan.

The implementation of a psychosocial rehabilitation service known as Comprehensive Community Services (CCS) was a priority in FFY 2008 for the DMHSAS, and will continue as a priority in FFY 2009. The CCS administrative rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial rehabilitation services for children and adults whose needs require more than outpatient therapy, but less than intensive community-based treatment. Certified CCS programs are funded by Medicaid with a county match. CCS* complements other services provided by most counties to make a more comprehensive array of mental health services available to consumers. The Medicaid reimbursable services include integrated treatment for individuals with co-occurring mental health and substance abuse needs.

*For More Details on CCS See Section "Available Services--Adults."

Wisconsin is working toward better coordination of the children's welfare system with the mental health system of care.

Child Welfare Program Enhancement Plan

In August of 2003, Wisconsin’s child welfare program underwent a Child and Family Services Review conducted by the federal Administration for Children and Families. As a result of this
review, Wisconsin submitted a Child Welfare Program Enhancement Plan (PEP). The action steps Wisconsin will take to improve child safety, permanency and well being are outlined in the Matrix portion of the PEP. The PEP Matrix includes 20 specific action steps to improve child welfare program outcomes and systemic factors. One of these action steps requires Wisconsin to work with children’s mental health experts and county and tribal child welfare agencies to develop a statewide policy on the screening and assessment of the mental health needs of children who have been abused or neglected. Another seeks to provide support to workers through training and technical assistance to identify mental health issues of children and parents and address them in the ongoing services case plan.

In March of 2007, an administrative memo was sent to tribal and county child welfare agencies to describe the process for applying for funds to participate in a mental health and substance abuse screening pilot project for children and families involved in the child welfare system. Proposals and requests for funding were received by the Division of Mental Health and Substance Abuse Services in April of 2007. Proposals were evaluated and 10 counties (Outagamie, Grant, Brown, and Sawyer, Marquette, Menominee, Columbia, Bayfield, Sheboygan, and Jackson) were funded for pilot projects through dedicated funds from the MHBG.

The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, and also on the impact of on trauma. The new pilot will target five counties in the northeast region of the state.

**Adolescent and children mental health residential treatment facilities identify and treat trauma.**

Many of the youth residential providers are providing trauma informed care (TIC) including: Children’s Hospital and Health System, Lad Lake, Lutheran Social Services, Homme Youth and Family, Norris Adolescent Center, Northwest Counseling and Guidance Clinic day programs, Northwest Passage, St. Charles Youth and Family Services, St. Amelia's, and St. Rose. They have active plans to implement TIC in their organizations.

Many ‘adult’ service providers are also getting a clear message that parenting is highly influential to a person’s well-being. As they treat adults, they are beginning to ask about the children and inform parents / providers about the negative consequences of traumatic stress on early brain development.

### 2. Provider Capacity

**Wisconsin is promoting workforce development.**

The DMHSAS will seek out partnerships with Universities to develop and promote the expansion in the number of child-adolescent and other Psychiatrists in the state and other possible solutions for the workforce shortages. The state is working to encourage private psychiatrists to provide community mental health services and recently recruited retired psychiatrists for part-time public sector positions. Additionally, the state is working with medical schools to focus residency programs on public sector service.
3. Funding

*Wisconsin is working toward mental health and substance abuse parity.*

The Legislative and Policy sub-committee of the Mental Health Council is active in Wisconsin in promoting mental health parity. The Mental Health Council has presented position papers that support parity to the Legislature. Mental Health America (MHA) and NAMI Wisconsin are very active as well in promoting parity around the state. A number of activities such as rallies and running races to bring attention to the issue have been held during recent years. Wisconsin's Lieutenant Governor Barbara Lawton sponsored a Rally Day for Parity in 2008 and promises to continue her leadership to promote parity legislation.

4. Data

*Wisconsin is improving the state data collection system for children's mental health outcomes.*

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, DMHSAS is developing 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. 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 the Division can use in a variety of ways: as a teaching tool; a measurement tool; an assessment adjunct; and a peer review mechanism. This quality improvement (QI) effort has started 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.

**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, Dr. John Lyons, the CANS-MH was modified for use by Wisconsin's ISP's and CST's to include items in addition to mental health related items such as child safety items.

Current Highlights

There are currently 47 individuals representing 35 sites as well as 4 staff from White Pine Consulting Services who are "Certified CANS Trainers." These individuals were trained by John Lyons, Ph.D. in January and August 2008, are certified to train others in their CST/ISP project as raters of the CANS. There are currently 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 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 Lyons 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 Work Plan for 2009.

A "CANS" page on the 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.

A web-based data collection system is in place to evaluate children's mental health programs in the state.

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 the Integrated Service Programs (ISP) and
Coordinated Service Teams (CST). The effort to improve the data system for these children’s mental health programs was funded by Wisconsin’s Mental Health Data Infrastructure Grant. 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 Bureau of Prevention Treatment and Recovery (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.

5. Stigma

*Wisconsin's adult and children's mental health systems address the President's New Freedom Commission Goals.*

The goals of the NFC can be found in many components of Wisconsin's vision for its adult and children’s system. In regard to Goal 1, physical and mental health integration is being promoted in three basic areas: education of primary care physicians in brief screening for mental health so that physicians are trained in identifying mental health problems and referring patients to mental health providers; promotion of education for mental health professionals and case managers in physical conditions to ensure coordination of care between community mental health programs and primary care; and, requirements in all publicly funded mental health programs for comprehensive physical health assessments and integration of physical health needs in treatment plans.

In addition, Anti-Stigma campaigns at the state and local level continue to reduce stigma so people are more comfortable seeking the mental health services they need. Goal 2 which calls for a consumer and family focus is a central tenet of the Wisconsin vision to be incorporated through consumer and family involvement in treatment planning and service delivery in both the Community Support Programs based on ACT and the Comprehensive Community Services program which is a psychosocial rehabilitation program serving people across the lifespan. Wisconsin has been pursuing the elimination of disparities described in Goal 3, for example, by attempting to pass parity legislation that raises mental health insurance coverage to be more comparable to coverage for physical health issues. Prevention and early intervention is another central tenet of the Wisconsin vision that is similar to Goal 4 of the NFC illustrated by our initiatives for suicide prevention in youth and identification of depression in post-partum women.

Wisconsin continues to pursue Goal 5 to provide the best treatment by implementing evidence-based practices in local programs by promoting them at annual conferences and by special competitive initiatives with local agencies serving individuals with serious mental illness. In accordance with Goal 6, Wisconsin will continue to use and expand tele-health technology to provide access to mental health services in rural areas of the state.
Wisconsin

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

4. Recent Significant Achievements

Directions: A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Infant Mental Health Activities

BACKGROUND

The Governor's Kids First Initiative of 2005 recommended the implementation of Wisconsin's Infant and Early Childhood Mental Health Plan. As a result, the DHS Infant Mental Health Leadership Team (DHS IMHLT) formed. The membership includes representatives from the Divisions of Mental Health and Substance Abuse Services, Public Health, Long Term Care and Health Care Access and Accountability. The mission of DHS IMHLT is to integrate infant and early childhood mental health principles and practices across all divisions in DHS as well as other Departments and community organizations.

Infant Mental Health is the developing capacity of children from birth to age three to:

- experience, regulate and express emotions,
- form close and secure interpersonal relationships, and
- explore the environment and learn,

all within the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development. Infant Mental Health is essential for learning and success in life.

(ZERO to THREE Infant Mental Health Task Force, 2003)

The DHS IMHLT has been meeting since 2006 and has developed policy recommendations based on an analysis of the gaps in infant mental health services in Wisconsin. The following recommendations suggest steps toward an integrated approach to increasing access to services, increasing provider capacity, and implementing best practices in the provision of mental health services to children aged zero to five.

IMHLT POLICY RECOMMENDATIONS

I. Early identification of social emotional delays in children under the age of five should be implemented through a universal screening DHS protocol.

II. Utilization of DC:0-3R should be encouraged and monitored. Technical assistance should be provided based on data showing need for increased capacity or training, including need for training within state departments.
III. Information on early childhood mental health should be disseminated to mental health providers, early childhood workers, public policy makers and other stakeholders.

IV. Infant and early childhood principles and practices should be integrated across Divisions in DHS as well as other Departments and stakeholders.

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 to local early childhood multi-system groups regarding development of community infant mental health plans
- Held first state-wide infant and early childhood mental health conference

Selected goals for 2009-2010 include:
- Standardization of screening objectives across diverse divisions and systems of care
- Integration of children's mental health and primary health care services
- Full implementation of DC:0-3R in Wisconsin
- Provision of training and technical assistance on DC:0-3R
- Implementing an IMH endorsement process for professionals across disciplines and systems

Seclusion and Restraint Practices with Children

Over the last ten years, the use of seclusion and restraint has received national attention, has come under increased scrutiny and many States and programs have implemented measures to reduce its use and provide training to staff to develop positive behavior reinforcement skills in de-escalating situations that might end up being physical. It has been clearly recognized that physical restraint is an inherently dangerous practice, not only for the child being restrained, but for the staff who are enforcing it. In addition, it has been reported that for many children the practice of seclusion and restraint is detrimental for it often traumatizes the child, can damage therapeutic relationships, and can impede recovery. Lastly, its use can result in serious liability concerns for the programs in which it occurs. Many national organizations and governmental entities have raised concerns about deaths and injuries that have resulted from its use and question its effectiveness as a treatment modality particularly when it is imposed as a “means of coercion, discipline, convenience, or retaliation by staff.”

The Wisconsin Department of Health Services (DHS) has gone on record regarding the detrimental effects of these coercive activities, convened workgroups to reduce their use, and over the past 15 months has sponsored three training programs for approximately 22 providers and 460 participants that have focused on the goal of reducing seclusion and restraint in community-based programs regulated by DHS and the Department of Children and Families (DCF).

The Disability Rights Report (DRW) report “A Tragic Result of a Failure to Act: The Death of Angellika Arndt” was released in December 2008. The report addressed the May 31, 2006 death of Angellika Arndt that was directly related to restraint at a day treatment facility. While this report recognized DHS/DCF efforts, it also challenged the Departments to do more and move faster.
Karen Timberlake, the Secretary of the Department of Health Services agreed with many recommendations of the report and renewed the DHS commitment to this important issue. On March 13, Secretary Timberlake responded to DRW agreeing to act on most of the 16 recommendations of the report.*

*For More Information on Developments in Seclusion and Restraint, See Section "Available Services--Children."

Child Welfare Screening Pilot

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.*


Community Comprehensive Services Serves More Children

The Community Comprehensive Services (CCS) initiative is continuing to serve more children each year. At the end of 2007, CCS was serving 146 individuals under age 21 which was 15 percent of the total. In the spring of 2008 the proportion served had already increased to 17 percent under age 21.*

*For More Information on CCS, See Section "Available Services--Adults."

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 Prevention and Treatment Block Grant funds, state general purpose revenue, and child welfare funds. 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.

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.*

*For More Information on CST, See Section "Available Services--Children."

**Youth Suicide Prevention Initiative Expansion with Department of Public Instruction**

The Department of Public Instruction (DPI), Mental Health America (MHA) and the DHS/Bureau partnered in 2007 to link suicide prevention efforts to ongoing projects on children’s mental health. $30,000 of the MHBG was allocated to Suicide Prevention in 2007 and 2008. Focus was on three distinct areas: classroom curriculum, toolkit development and duplication, and children’s mental health web casts for schools.

The DPI Suicide Prevention toolkit revisions provided updated interventions and resources to make the toolkit a unified piece and will promote the new middle school Signs of Suicide (SOS) curriculum. These collaborative efforts between departments support the legislative mandate found in WI 115.365, including assistance to schools for suicide prevention programs, requiring DPI and DHS to collaborate in multiple ways to reduce youth suicide in Wisconsin. Notably, the law requires, “coordination of school suicide prevention programs and activities,” as well as “consultation and technical assistance to public and private schools for the development and implementation of suicide prevention programs…”

Wisconsin is a leader in purchasing the high school SOS program, with about 250 kits in approximately 425 high schools statewide. SOS can be easily implemented and is cost-effective. It is the only school-based program to show a reduction in suicide attempts (by 40 percent) in a randomized controlled study (American Journal of Public Health, March, 2004), and was selected by SAMHSA for its National Registry of Evidence-based Programs and Practices (NREPP).

DPI worked to train middle school staff in using the SOS materials along with the middle school curriculum; however, as there are almost twice as many middle schools than high schools, training efforts are more complex. The SOS program teaches youth how to identify symptoms of depression, self-injury, and suicidality in themselves or their friends and to respond effectively by seeking help from a trusted adult. The program's primary objectives are to educate adolescents that depression is a treatable illness and to equip them to respond to a potential suicide in a friend or family member using the SOS technique. SOS is an action-oriented approach instructing students how to ACT (Acknowledge, Care and Tell) in an emergency.

Finally, DPI developed, coordinated and funded speakers for a web cast series on mental health issues for school staff, including pupil services, administrators, and teachers. Past workshops and conference presentations have shown there is a very high need for mental health information for schools. Two recent surveys have confirmed this opinion on the part of health educators, principals, and school psychologists. DPI coordinated a series of presentations including one joint web cast with DHS. These web casts are located on the DHS and the DPI web sites.
Hiring of a Trauma Coordinator and Trauma Prevention Activities

A trauma coordinator was hired in April of 2008. The trauma coordinator is responsible for collaborating with consumers and other mental health and substance abuse systems' stakeholders in the planning, development and implementation of trauma informed care in community-based mental health, substance abuse and other human service settings. In addition to increasing trauma-related awareness in the services community, this initiative will improve mental health and substance abuse services to people impacted by trauma.*

*For Details on Trauma Prevention Activities See Section "Available Services Adults."
Wisconsin

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
Section II - Identification and Analysis of the Service System's Strengths, Needs and Priorities

5. State's Vision for the Future

Directions: A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Wisconsin's Vision for the Future

Wisconsin's plan for its comprehensive community-based mental health system has many similarities to the goals of the President's New Freedom Commission on Mental Health (NFC) established in 2003. The six primary goals of the NFC include:

1. Americans understand that mental health is essential to overall health,
2. Mental health care is consumer and family driven,
3. Disparities in mental health services are eliminated,
4. Early mental health screening, assessment, and referral to services are common practice,
5. Excellent mental health care is delivered and research is accelerated, and
6. Technology is used to access mental health care and information.

Wisconsin's Mental Health system transformation efforts including Comprehensive Community Services (CCS) initiative in the adult system and the Coordinated Service Team (CST) and Integrated Services Projects (ISP) initiatives in the children's system all incorporate the NFC's vision and goals 2, 4, 5 and 6.

Wisconsin has established a goal for its mental health system:

“All persons in need of mental health services across Wisconsin have access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity.”

The ideal service system will target prevention, early intervention, treatment, recovery, consumer and family involvement and participation, consumer and family-centered service delivery, a culturally competent workforce and services, and reduction of stigma.

Transformation Activities

In step with the goals of the President's New Freedom Commission on Mental Health (NFC), Wisconsin plans to continue its prioritization of implementing system transformation and promote recovery-based services development in FFY 2010. Currently, Wisconsin is developing a model of services and supports that braids together the Medicaid Health Management Organization (HMO) services that include both psychiatric inpatient and outpatient care with those psycho-social rehabilitation services provided by local county agencies. This braided system provides comprehensive physical health and mental health care for consumers who have needs beyond outpatient services. This shift in focus due to legislative action that ordered the expansion of SSI managed care statewide provided the opportunity for DMHSAS to focus on elements of transformation beyond the coordination of funding issues that dominated the previous redesign initiative.
Newly-funded parts of the transformation initiative in FFY 2009-2010 will implement results of the strategic planning for the local public mental health system. Efforts may include the current funding and responsibilities of the county-based system, as well as the Medicaid and BadgerCare mental health and substance abuse service delivery system. The goal will be to increase access and streamline and improve outcomes of services to consumers.

**Objective:** Transform the Wisconsin Public Mental Health system into an integrated model of services and supports that braids multiple funding sources.

**Recovery Activities**

DMHSAS has augmented their transformation efforts with the addition of a recovery and consumers affairs coordinator and the creation of a consumer run, statewide Recovery Implementation Task Force to help DMHSAS plan strategic changes in current psychosocial rehabilitation services that would transform delivery of services across the state at the local level.

Wisconsin increased the allocation of the Mental Health Community Services Block Grant (MHBG) to Family/Consumer Self-Help and Peer to Peer Support Programs from $874,000 to $991,629 annually in 2008. While some other states do not directly fund peer support services, Wisconsin is proposing to set aside 13.4 percent of its MHBG for this purpose. Wisconsin funds a variety of consumer recovery and peer support programs including programs that work with adult consumers, child consumers, and families of consumers.

**Consumer Focused Recovery**

Wisconsin needs to focus on the goal of creating a system that is recovery-oriented and consumer focused. A system where consumers and their families are integral to treatment planning, and all individuals are treated with respect and dignity, and treatment emphasizes hope and optimism, is strength and recovery-based, and culturally competent and culturally affirmative. Our goal statement calls for a future where prevention, detection, and early intervention and treatment occur, and recovery is commonplace, and everyone across their life span has supports to live, learn, work, and participate fully in their own community. In that transformed and integrated system, community values are embraced, peer support and consumer involvement expected, self determination respected, and flexible support services evolve as needs change. Mental health, public health, primary and acute health care, substance abuse services, justice, and other systems will need to work together to assure this.

In order to achieve this goal, the Division needs to move to a further stage of development in fostering the consumer movement in Wisconsin. The DMHSAS will be focusing its efforts in three areas: 1) developing and sustaining an infrastructure of strong self advocacy, family and consumer support, 2) developing and fostering education, and 3) empowering and adults and older adults, and growing consumer centers financially. This infrastructure building effort will a) foster consumer and family member involvement with statewide activities that link with other organizations and transformation initiatives of the Department; b) seek to continue to foster and grow consumer run organizations to promote self advocacy, skill building for employment and other activities of daily living in a strong peer support system as the Wisconsin system transforms into a recovery based, consumer focused, and family centered service delivery system; and, c) help sites with financial management of the consumer run centers to ensure fiscal responsibility as well as fostering ways to grow support from county and other funders.*
*See Section "State's Vision for the Future--Adults" for information on "Person Centered Planning/Trauma Informed Care Champions."

BPTR Recovery Coordinator Activities

A Recovery Coordinator was contracted through the University of Wisconsin School of Medicine and Public health, Department of Psychiatry to provide recovery program development support statewide. The position started in 2006. The position is funded through the Mental Health Block Grant. The Recovery Coordinator educates providers, consumers and other stakeholders regarding the implementation of recovery principles in mental health treatment and support services. The goal is to increase both mental health consumers' and providers' understanding of recovery and to transform our current system toward incorporating recovery principles.

The specific activities of the Recovery Coordinator include:

- Provide Recovery 101 and recovery concepts in practice trainings to community stakeholders across Wisconsin.
- Partner with consumers, advocates, providers and families to facilitate systems transformation, incorporating recovery, person-centered planning, dual recovery and evidence-based practices.
- Participate on planning and implementation teams working on CCS, CSP, outpatient care and inpatient care in order to best utilize recovery concepts within program models.
- Provide leadership and support to the development of Wisconsin certified Peer Specialists as well as disseminate information to communities regarding Peer Specialists.
- Work with State Institutions to develop recovery based plans of care, trauma informed care, and person centered planning skills.

Objective: Expand funding for consumer and family programs and services in 2010.

Trauma Coordinator*

A trauma coordinator was engaged through a partnership with the University of Wisconsin-Madison in April of 2008. The trauma coordinator is responsible for collaborating with consumers and other mental health and substance abuse systems' stakeholders in the planning, development and implementation of trauma informed care in community based mental health, substance abuse and other human service settings. In addition to increasing trauma-related awareness in the services community, this initiative will improve mental health and substance abuse services to people impacted by trauma.

*For Details on Trauma Prevention Activities See Section "Available Services Adults."

Evidence-Based Practices

An essential step to implementing the goals of the NFC is Wisconsin's plan to assess and implement evidence-based practices (EBP) for adults and children. The transformation efforts include the fostering of evidence-based practices in pilot counties (currently five counties are participating). The five counties participating include: Marathon, Brown, Kenosha, Richland and Jefferson.*
*For details on activities and outcomes of the pilots, see the Adult Section "Recent Significant Achievements."

**Child Welfare Screening Pilot**

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.

The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, and also on the impact of trauma. The new pilot will target five counties in the northeast region of the state.

**Objective:** Continue to evaluate the efficacy of the Child Welfare Screen and expand the initiative to additional counties.

**Wisconsin Will Continue to Work Toward Improving the Quality of Services for Infants and Young Children**

The Department of Health Services Infant Mental Health Leadership group has identified the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) as a priority for mental health clinicians providing treatment to children under the age of four. In 2008, the State Division of Health Care Access and Accountability approved the use of DC:0-3R diagnoses to bill for Medicaid services needed by children less than four years of age in Wisconsin. Few mental health clinicians receive training in working with infants in their graduate school programs and as a result, in-service training is required to build the knowledge and skills needed to effectively provide clinical interventions with this population. Training in the use of DC:0-3R is one step in building the needed knowledge and competencies.

In 2008, Mental Health Block Grant funds were utilized to provide training on the use of DC:0-3R. Wisconsin Alliance on Infant Mental Health (WI-AIMH) held the first state wide training on the DC: 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised) on September 15-17, 2008 in Madison, Wisconsin. The first day, “Awareness Training,” was a half day session that introduced infant and early childhood professionals to the concepts, principles, practices and theories of infant mental health. An overview of DC 0-3R as an approach to understanding and diagnosing disorders of early childhood was also provided. Over 60 professionals attended this session including representatives from Birth to Three, mental health, child welfare, and home visiting programs.
On September 16-17, 2008 the “Practitioner Preparation Training” was held. This training was designed for licensed mental health practitioners who are able to diagnose. Key concepts in infant mental health were reviewed and the development, philosophy and use of DC: 0-3R was highlighted. In small group discussions, participants applied clinical reasoning and diagnostic thinking to case studies and used the Decision Guidelines to experience the diagnostic process. Over 25 mental health practitioners from a variety of disciplines, including social work, psychology, marriage and family therapy and counselors attended these sessions. Six clinicians were chosen to participate in the train the trainers program. Monthly consultations for a year with the national trainer will be provided for those in the train the trainers programs. Additionally, the participants of the “Practitioner Preparation Training” have been invited to attend the monthly consultations to further their own understanding of the diagnostic process.

Based on both the evaluations received and verbal feedback, this was an excellent and useful training for those who attended. Early childhood professionals now have an overview of the diagnostic tool used for infants, toddlers and young children and will be able to use the same language and understanding when collaborating across disciplines. Additionally, mental health practitioners appear eager to continue learning more about assessment, diagnosis and treatment of infants, toddlers and young children. This training was repeated in March 2009 in Eau Claire and in September 2009 in Wausau.

Wisconsin to Acquire Michigan Endorsement Process for Infant Mental Health Providers

Infant and Early Childhood Mental Health Endorsement is a verifiable process that supports professional development across different disciplines for professionals working with infants, young children and their families. Endorsement recognizes individual's achievements in training, education, and experience. Michigan Association for Infant Mental Health spent years developing the endorsement process and has received a national award for innovative educational practice in improving workforce development. Wisconsin is working toward acquiring the Michigan Endorsement process for its infant and early childhood providers. With this endorsement in place, Medicaid would be more likely to support DC:0-3R claims and to acknowledge infant mental health providers. The State of Wisconsin has made significant achievements in professional development for early care and education professions and Wisconsin Alliance for Infant Mental Health (WI-AIMH) will build on these accomplishments. Specifically, WI-AIMH will:

1. Acquire Michigan Infant Mental Health Endorsement process.
2. Develop web site and promotional materials.
3. Deliver intensive reflective practice technical assistance.
4. Review the Registry's Infant-Toddler Credential and the Inclusion Credential to determine if consistent with Michigan's Level 1 (Infant Family Associate).
5. Level 2 though 4 will be "housed and managed" at the WI Alliance for Infant Mental Health. (Level 2 is the Infant Family Specialist, Level 3 is the Infant Mental Health Specialist and Level 4 is the Infant Mental Health Mentor.)
6. Review applications, grade exams and keep records.
**The Michigan Model Endorsement Process and Its Interface with the Wisconsin Registry**

The Registry, Wisconsin's Recognition System for the Childhood Care and Education Profession, acknowledges and highlights the technical assistance, experience and professionalism that is vital to quality child care.

The Registry awards a certificate verifying entry level and continuing education requirements defined by the State of Wisconsin Department of Children and Families. Technical assistance and education are also verified and represented by the levels of The Registry's career ladder. The certificates honor each recipient's unique training background and provide a tool for demonstrating their qualities and strengths as well as their professional image.

WI-AIMH will align the applicable Wisconsin Registry certificates with MI endorsement level (Wisconsin endorsement once purchased). For example, the Registry has an Infant and Toddler Credential and WI-AIMH will align it with Wisconsin endorsement so professionals do not have to be “certified” in two places. WI-AIMH will work with the Registry staff to potentially adjust their requirements and ensure the competencies line up. Another applicable certificate is the Inclusion Credential. WI-AIMH will again review the curriculum and competencies of this credential and compare-contrast with Michigan endorsement to determine if the competencies meet the requirements of the Michigan endorsement and at which level.

**The Case-Based Continuing Education Pilot Program (CBCE)**

The CBCE pilot program (funded through the 2008 MHBG) was developed to establish an innovative model to provide continuing education. The "case-focused" approach was proposed to encourage various types of treatment professionals--who were all connected with a particular child or adolescent receiving services--to obtain their continuing education together, facilitating team building and coherent treatment planning. This model provides a common educational experience focused on current, evidence-based professional literature, and is exceptionally relevant to professionals. It also provides a forum for open discussion and exchange of ideas between professionals, and assists with improved coordination of care among professionals.

Activities and Deliverables of the CBCE program included:

- Develop and distribute the marketing brochure and case information form.
- Evaluate "cases" for selection in coordination with DHS.
- Establish primary site contact(s) to assist with program.
- Develop request and organization procedures for case records.
- Review and summarize the disparate records received.
- Provide overall coordination and scheduling of program components (meetings, email and telephone calls, scheduling, troubleshooting, etc.).
- Search, identify and distribute CBCE literature readings.
- Deliver CBCE via distance "real-time" audio/video technologies.
- Provide flexible, site-specific and case-dictated approaches.
- Create and distribute participant feedback forms.
- Distribute certificates of attendance to participants.
- Evaluate capability to provide CBCE services in an ongoing manner (i.e., move beyond the pilot).
A DHS approved brochure and data-gathering form was sent out to all Wisconsin Counties (72) to solicit participation in the pilot. A small number of inquiries were sent back and ultimately three cases were selected for participation in the study.

Results
There appeared to be a differential response about the benefit of CBCE when comparing supervisory versus "front-line" workers. Front line workers, in general, desired from the CBCE program specific suggestions on what they could/should do with/for their client (despite this not being the intended purpose of CBCE), whereas the supervisory professionals appreciated the unique (and sometimes theoretical) approach that the CBCE pilot provided via the evidence-based and best practices professional readings, as well as the CBCE presentations and discussions that were focused on in this literature.

The contractors reported that they anticipate that the CBCE program will result in improved care for the children and adolescents entrusted to the charge of the 26 professionals that participated. The program components of a) review of the current "best-practice," evidence-based treatment literature, b) presentations by an experienced clinician, and c) the guided discussions that ensued, served to increase the knowledge base of the Wisconsin professionals that participated in the CBCE program.

The contractors also reported that they discovered that, despite careful and repeated explanations that CBCE was an educational program, many of the participating professionals expected the program to provide direct clinical case consultation in addition to continuing professional education. They stated that this likely reflects a strongly felt need for direct clinical consultation, which appears to overshadow the need for continuing education. Additionally, the professionals stated that the expert clinical consultation is simply not available in their community. The contractors recommended that exploring modifications to the CBCE model itself to provide some measure of direct case consultation in conjunction with education. This service would serve to further enhance the relevance of the educational message, while directly meeting urgent clinical needs.

Addressing Workforce Development: Increasing Access to Children and Adolescent Psychiatrists and Other Mental Health Professionals

The DMHSAS will seek out partnerships with Universities to develop and promote the expansion in the number of child-adolescent and other Psychiatrists in the state and other possible solutions for the workforce shortages. The state is working to encourage private psychiatrists to provide community mental health services and recently recruited retired psychiatrists for part-time public sector positions. Additionally, the state is working with medical schools to focus residency programs on public sector service.

Objective: Increase access to child psychiatrists and other mental health providers.

Access to Children's Mental Health Services

Wisconsin's goal for children's mental health services includes using a wraparound approach to service delivery.
The vision for Wisconsin's children's mental health system is best embodied in its current CST Initiative which uses a wraparound approach to service delivery. The wraparound approach is an evidence-based practice. The goal is:

“To implement a practice change and system transformation in Wisconsin by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families who require substance abuse, mental health, and child welfare services.”

The ideal would be that the children’s mental health system would have a wraparound service delivery system in every county. Important components of the CST vision that fit with the NFC goals include the emphasis on consumer and family-driven services (Goal 2 of the NFC). One of the CST goals is the individualization of treatment plans with child and parent involvement in the planning process. Service plans and treatment delivered through CSTs are designed in a culturally competent manner (Goal 3). Screening for co-occurring disorders and the integration of the mental health system with school systems, the juvenile justice system and primary care are also central tenets of the CST Initiative (Goal 4). The use of the wraparound service delivery approach illustrates how CSTs are using some of the best practices available (Goal 5). In accordance with Goal 6, Wisconsin will continue to promote and expand the use of tele-health technology particularly to promote access to child psychiatry in rural areas of the state.

Wisconsin continues to work annually to expand the number of counties that have a Coordinated Service Team (CST) in order to reach the goal of eventually having CST projects available for children and families in all counties. 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*

*For More Information on CST, See Section "Available Services--Children."
Wisconsin

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 1: Comprehensive Community-Based Mental Health Services

Directions: Provides for the establishment and implementation of an organized community-based system of care for individuals with severe mental illness.

Establishment of System of Care

Wisconsin’s Continuum of Care

Wisconsin’s comprehensive recovery-based mental health system provides a continuum of care which begins with prevention and places its emphasis on services based in the community. The continuum continues across the lifespan with more intensive services, including providing services in residential and inpatient settings where appropriate to the needs of the individual. The continuum also provides other services which help people attain their recovery goals, including medical and dental, educational, employment, housing, and support services, and services targeted at special populations, such as older adults, the deaf and hard of hearing population, the homeless and individuals with both mental health and physical conditions requiring treatment and support.

Community-Based Services

Outpatient Mental Health Services

Psychotherapy, evaluation, counseling/therapies, and psychopharmacologic management are provided to individuals with mental health problems on an appointment basis. These individuals are typically not in need of more intense hospital services or ongoing daily monitoring to prevent deterioration of their mental health. This service is provided through a certified clinic that provides comprehensive professional services by psychiatrists, psychologists, and master level therapists. Medicaid state funding provides the non-federal share of these services in clinic or institutional settings, and counties provide the match to federal financial participation (FFP) for intensive outpatient mental health services provided in a home or community setting. (Intensive outpatient mental health services include: Community Support Programs; Comprehensive Community Services Programs; Targeted Case Management services; Crisis Intervention Services; and In-home/Community services for adults.) Psychologists and psychiatrists also provide these services in independent private practice. Over 818 public and private clinics are certified by the state and provide services to over 70,000 individuals in the public mental health system annually, in addition to thousands of persons who are not in the public system. 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://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf](http://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf)

*For more detail on revision of the outpatient rule, see Adult Section "Legislative Initiatives and Changes."

**Community Support Programs**

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 severe mental illnesses. The program uses an Assertive Community Treatment (ACT) model, which was developed at the Mendota Mental Health Institute in Wisconsin. The ACT model has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, rehabilitation, crisis, and supportive services. CSPs serve persons who have a serious severe mental illness that affects both their ability to live independently in the community and to function in major life roles.

The array of required treatment services available to CSP consumers include: case management; crisis intervention; symptom assessment; medication management and education; medication prescribing and monitoring; psychiatric evaluation and treatment; and family, individual or group psychotherapy. The required 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.

The state provides funding for CSPs through community aids and Mental Health Block Grant (MHBG) funds. In addition, Wisconsin Act 16 appropriates $1,000,000 state General Purpose Revenue (GPR) funds annually to improve access to CSPs using it to match federal funding for individuals eligible for Medicaid.

The Division of Mental Health and Substance Abuse Services (DMHSAS) makes direct GPR funding available to counties interested in establishing a certified CSP, and provides technical assistance to meet the criteria for ACT laid out in Administrative Rule DHS 63. In 2006, Iron County was given $80,000 to establish a new CSP, and obtained provisional CSP certification early in 2007. Some examples of service delivery development include: local systems change to provide for comprehensive access; a fluid continuum of care; revision of assessment and care plan processes and forms to assure they are recovery-based; processes that involve the consumer at all points in the process of creating a treatment plan; staff training in outcomes, trauma-informed treatment and recovery-based treatment; and, determining how outcomes for consumers and general quality service delivery will be measured at the local level.

By spring 2008 there were 78 CSPs in Wisconsin (see map, below) which meet the standards for CSP certification established by the DHS. In CY 2007, CSPs served 5,771 persons. DMHSAS will continue its efforts to promote program certification in counties without a certified CSP.

**Case Management**
As noted previously, case management is an integral part of Wisconsin's services. All of Wisconsin counties provide some level of case management for persons who have a serious severe mental illness.

**Targeted Case Management**

Targeted case management is a mechanism for coordinating and arranging services. It includes ensuring comprehensive assessment and regular reviews of assessment and recovery plans, follow-up and monitoring of referrals, coordination of services available at the local level, and coordination of crisis services. Each county provides case management, which is a linkage connecting individuals to services provided by multiple mental health, housing, or rehabilitation programs in the community. For MA recipients, counties may bill the MA program for targeted case management services, and the county provides the match to FFP from non-federal funds.

**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.

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

**Nursing Home Relocation Planning**

Wisconsin received two grants from the Centers for Medicare and Medicaid Services; a Real Choice Systems Grant and a New Freedom Initiative Grant. The DMHSAS has identified key nursing facilities that have significant numbers of residents with mental health diagnosis and that have expressed willingness to jointly plan with county staff for community placement. One goal is to ensure that the system incorporates best practice models that include comprehensive, recovery-based assessment and planning. Relocation involvement at the time of facility closure or downsizing is also actively pursued as a time to provide technical assistance regarding community placement options. In January 2007 Wisconsin received approval of its proposal for a Money Follows the Person Demonstration Grant.
The Community Opportunities and Recovery (COR) is a relocation waiver for people living with serious severe mental illness and a co-occurring physical disability in a nursing home and want to move to the community. Due to the amount of time it took to develop the governing policies, procedures and the corresponding manual materials for this new 1915 (c) home and community based services waiver, the effective date was amended with the Centers for Medicare and Medicaid Services (CMS) to January 1, 2008.

Numerous meetings and contacts were made with those counties who had not already transitioned to Family Care. (Once Family Care is implemented in a county, the COR waiver is wrapped into it and no new participants are enrolled in COR.) During 2008, Dane County successfully implemented the COR waiver and relocated four individuals from their county operated nursing home. None of these four individuals were eligible for the Money Follows the Person Project.
Wisconsin

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 1: Comprehensive Community-Based Mental Health Services

Directions: Describes available services and resources in a comprehensive system of care including systems for individuals with both severe mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and other activities leading to reduction of hospitalization.

Available Services

Health, Mental Health, and Rehabilitation Services

Wisconsin’s Mental Health Programs and Services

The Wisconsin public mental health system is a county-based system built on the foundation that all 72 counties have a responsibility to make decisions about mental health services provided to their constituents. In 1971, Wisconsin Statutes s. 51.42 mandated a system of community-based mental health care that is accessible to all individuals with serious and persistent severe mental illness and to children with a severe emotional disorder (SED). Wisconsin’s public mental health system has built a partnership between the county/tribal service provision and state and county/tribal funding to deliver mental health services. The provisions of Chapter 51 delegate the Department of Health Services (DHS) authority to promulgate rules and establish standards for mental health services.
Certified Public Mental Health Programs

The following table gives an overview of the current certified mental health programs in the state.

Table 6: Certified Mental Health Programs (February 2008)

<table>
<thead>
<tr>
<th>Number of Programs</th>
<th>Program Area</th>
<th>Regulated by:</th>
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<tbody>
<tr>
<td>44</td>
<td>Inpatient</td>
<td>DHS 61.70 – 61.72</td>
</tr>
<tr>
<td>19</td>
<td>Emergency Service 2</td>
<td>DHS 34 Sub II</td>
</tr>
<tr>
<td>44</td>
<td>Emergency Service 3</td>
<td>DHS 34 Sub III</td>
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<td>23</td>
<td>Day Treatment</td>
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<td>15</td>
<td>Adolescent Inpatient</td>
<td>DHS 61.79</td>
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<td>Day Treatment Services for Children 1</td>
<td>DHS 40 Level I</td>
</tr>
<tr>
<td>10</td>
<td>Day Treatment Services for Children 2</td>
<td>DHS 40 Level II</td>
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<tr>
<td>5</td>
<td>Day Treatment Services for Children 3</td>
<td>DHS 40 Level III</td>
</tr>
<tr>
<td>818</td>
<td>Outpatient</td>
<td>DHS 61.91 – 61.98</td>
</tr>
<tr>
<td>78</td>
<td>Community Support Programs (CSP)</td>
<td>DHS 63</td>
</tr>
<tr>
<td>26</td>
<td>Comprehensive Community Services</td>
<td>DHS 36</td>
</tr>
</tbody>
</table>

Wisconsin’s Continuum of Care

Wisconsin’s comprehensive recovery-based mental health system provides a continuum of care which begins with prevention and places its emphasis on services based in the community. The continuum continues across the lifespan with more intensive services, including providing services in residential and inpatient settings where appropriate to the needs of the individual. The continuum also provides other services which help people attain their recovery goals, including medical and dental, educational, employment, housing, and support services, and services targeted at special populations, such as older adults, the deaf and hard of hearing population, the homeless and individuals with both mental health and physical conditions requiring treatment and support.

Mental Health Services for Individuals who are Older Adults

According to a national report in 2005, one in four older adults has a significant mental disorder. Among the most common mental health problems in older persons are depression, anxiety disorders, and dementia. Over the next 25 years, the number of older adults with major psychiatric illnesses will more than double from an estimated seven to 15 million individuals. Using these 2005 national population estimates in Wisconsin and the 2005 MH/SA prevalence estimate, (one in four older adults has a significant mental disorder). The Department of Health Services expects to see approximately 243,328 older adults (60 years or older) or 181,896 older adults (65 years or older), in need of a MH/SA intervention. The Wisconsin public human service data system (HSRS) for year 2005 shows approximately 8,941 older adults aged 60 years or older (out of 97,265 total persons in this target group, or nine percent) were receiving a public mental health service, and approximately 2,225 adults over age 60 (out of 81,181 persons or 2.7 percent) were receiving a substance abuse service. This does not reflect those individuals who receive services from Medicare.
**Adult Disability Resource Centers**

Wisconsin is investing 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 severe mental illness), or their families. The Division of Mental Health and Substance Abuse Services is providing 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.

As of January 2009, there were 28 operational ADRCs serving 40 counties. The ADRC of Southwest Wisconsin-North expanded to serve Crawford County. This gives 67.2 percent of Wisconsinites over age 18 access to an ADRC. DHS has received and reviewed the application from the multi-county and multi-tribal collaboration between Bayfield, Iron, Ashland, Sawyer and Price counties and the Bad River, Lac Courte Oreilles and Red Cliff tribes. The Department is working with current applicants including the multi-county collaboration between Barron, Washburn and Rusk Counties, Pepin, Buffalo and Clark Counties, Douglas County and the multi-county and tribal collaboration between Polk and Burnett Counties and the St. Croix Tribe. Discussion also continues with Milwaukee County to establish the Disability Resource Center. Locations of the current ADRC’s is available at:

http://DHS.wisconsin.gov/LTCare/generalinfo/adrcmap.pdf

**Rehabilitation Services**

The required array of rehabilitation services available to consumers within CSP and outside of the CSP include vocational assessment, job development, vocational supportive counseling, social and recreational skill training, and daily living support. As previously discussed the CCS benefit will expand rehabilitation services offered throughout Wisconsin, both geographically and to a wider array of consumers.

**Rehabilitation Services for Individuals with Severe Mental Illness who are Older Adults**

The Division’s efforts in providing services to older adults with severe mental illness is multi-faceted. The single largest source of funding in the community for Wisconsin older adults is the new long term care managed care program, Family Care. In order to access these services, Wisconsin older adults need to have physical conditions that need nursing management, or functional deficits that require assistance to perform basic activities of daily living. Approximately 55 percent of people enrolled in this long term care program have mental health diagnoses. The Division has been working on several levels with the Family Care program. The Division has provided several trainings and technical assistance events to the Aging and Disability Resource Centers, to allow them to perform intake and referral to people with severe mental illness seeking services. The Division has provided training at the MCO level for nurses and social workers in person centered planning for people with physical and mental health issues, has provided systems level assistance to the Division of Long Term Care staff on program development for specialized programs for people with mental health and substance abuse issues, and most recently has taken the lead in writing a grant to SAMHSA to improve services to older adults in conjunction with primary care physicians. One part-time person at the division level is dedicated to providing technical assistance to collaborating agencies that provide services to older adults with mental health issues. At the Division level, the key staff from Family Care and the key community care program staff from DMHSAS meet to identify program and service delivery
issues and engage in collaboration efforts to improve service delivery within the Departments contracted managed care organizations.

**Community-Based Services**

*Outpatient Mental Health Services*

Psychotherapy, evaluation, counseling/therapies, and psychopharmacologic management are provided to individuals with mental health problems on an appointment basis. These individuals are typically not in need of more intense hospital services or ongoing daily monitoring to prevent deterioration of their mental health. This service is provided through a certified clinic that provides comprehensive professional services by psychiatrists, psychologists, and master level therapists. Medicaid state funding provides the non-federal share of these services in clinic or institutional settings, and counties provide the match to federal financial participation (FFP) for intensive outpatient mental health services provided in a home or community setting. Psychologists and psychiatrists also provide these services in independent private practice. Over 818 public and private clinics are certified by the state and provide services to over 70,000 individuals in the public mental health system annually, in addition to thousands of persons who are not in the public system. Additionally, 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://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf

*See Section "Legislative Initiatives and Changes" for more details on the outpatient rule.

*Community Support Programs*

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 severe mental illnesses. The program uses an Assertive Community Treatment (ACT) model, which was developed at the Mendota Mental Health Institute in Wisconsin. The CSP Program has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, rehabilitation, crisis, and supportive services. CSPs serve persons who have a serious severe mental illness that affects both their ability to live independently in the community and to function in major life roles.

The array of required treatment services available to CSP consumers include: case management; crisis intervention; symptom assessment; medication management and education; medication prescribing and monitoring; psychiatric evaluation and treatment; and family, individual or group psychotherapy. The required 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.

The state provides funding for CSPs through community aids and Mental Health Block Grant (MHBG) funds. In addition, Wisconsin Act 16 appropriates $1,000,000 state General Purpose Revenue (GPR) funds annually to improve access to CSPs using it to match federal funding for individuals eligible for Medicaid.
The Division of Mental Health and Substance Abuse Services (DMHSAS) makes direct GPR funding available to counties interested in establishing a certified CSP, and provides technical assistance to meet the criteria for CSP laid out in Administrative Rule DHS 63. In 2006, Iron County was given $80,000 to establish a new CSP, and obtained provisional CSP certification early in 2007. Some examples of service delivery development include: local systems change to provide for comprehensive access; a fluid continuum of care; revision of assessment and care plan processes and forms to assure they are recovery-based; processes that involve the consumer at all points in the process of creating a treatment plan; staff training in outcomes, trauma-informed treatment and recovery-based treatment; and, determining how outcomes for consumers and general quality service delivery will be measured at the local level.

By spring 2008 there were 78 CSPs in Wisconsin (see map, below) which meet the standards for CSP certification established by the DHS. In CY 2007, CSPs served 5,771 persons. Some counties are sharing CSPs as they do not have enough enrollees to provide an economy of scale to support the infrastructure needed for a CSP.

DMHSAS provided start up funding and technical assistance to Iron county over a two year period to assist them to hire staff and meet the program requirements necessary to obtain certification, begin serving clients and billing Medical Assistance for services provided to Medicaid eligible clients under their Community Support Program. Walworth County also obtained certification for their CSP, and although they did not request start-up funding, the state provided technical assistance.

Of the eight counties remaining without a CSP, seven are rural counties. In the first half of FFY 2010, Wisconsin plans to offer a portion of the $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. DMHSAS will continue its efforts to promote program certification in counties without a certified CSP.
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 Iron. The following counties have more than one CSP: Brown (3), Dane (3), Marathon (3), Milwaukee (1), Price (2), Rock (3), Waushara (3).

Certified CSP

[Map of Wisconsin with counties marked as certified CSPs]
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 (as described previously) and mental health block grant funds. Start-up funds are used to provide to 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. 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; 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
To date, 27 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.
### STATUS OF COMPREHENSIVE COMMUNITY SERVICES (CCS) PROGRAMS AND PERSON-CENTERED PLANNING

**September, 2008**

<table>
<thead>
<tr>
<th>Counties</th>
<th>8 Start-Ups (2007 and 2008)</th>
<th>21 Certified CCS Counties</th>
<th>Completed PCP &amp; TA</th>
<th>PCP Anticipated, TA Needed</th>
</tr>
</thead>
</table>

1 = TA after Sept. trng.
2 = TA after Nov. trng.

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The Community Options Program

This Wisconsin program provides home and community-based services to those persons who are seeking or are at imminent risk of placement in a nursing home. The Community Options Program (COP) may be combined with MA card funded services to provide comprehensive and individualized care and to provide a safe, consumer-controlled alternative for individuals to live in their communities.

The COP funding target populations are elderly, persons with physical disabilities, persons with developmental disabilities, persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse. State funding is provided for initial screening and assessment, preparation of case plans and treatment services. Slots for persons with mental health needs are very limited. As reported for 2007, the COP served a total of 28,430 persons across the state including 1,102 persons with a serious severe mental illness, or 3.9 percent of the total population served through COP. This is a decrease from 2006, in which COP served 27,857 persons of which 5.2 percent had a serious severe mental illness. A total of $11,492,324 was spent on the SMI population in 2007. It should be noted that this represents 21 percent of the total COP-regular budget. (These numbers may not reflect the children who are autistic or seriously emotionally disturbed. Nor do the numbers include the Family Care population.)

Residential Services

Services for Persons Residing in Nursing Homes

The primary data set that provides information regarding the number of nursing home residents who have a severe mental illness is the Pre-admission Screening and Resident Review (PASRR) process. In 2006, the contracted PASRR agency completed 6,271 screens for persons who have a severe mental illness. Twelve (0.2 percent) of the persons screened were determined not to need nursing facility placement and 327 (5.2 percent) of the persons screened were found to need specialized psychiatric rehabilitation services, which are services necessary to prevent avoidable physical and mental deterioration, while maximizing the consumer’s functional abilities. 81.8 percent of the screens were for persons ages 65 and older and 71.4 percent of all the screens found that the person has a severe medical condition or severe cognitive losses. In 2007, the contracted PASRR agency completed 6,950 screens for persons who have a severe mental illness. Three (<0.1 percent) of the persons screened were determined not to need nursing facility placement and 395 (5.7 percent) of the persons screened were found to need specialized psychiatric rehabilitation services. Eighty-one point four percent of the screens were for persons ages 65 and older and 71.8 percent of all the screens found that the person has a severe medical condition or severe cognitive losses. During both 2006 and 2007, no persons who resided in a Medicaid-certified nursing facility at the time of the PASRR Level II Screen were found to require specialized services, a level of services comparable to requiring inpatient psychiatric hospitalization; although one person in 2006 and none in 2007 were prohibited from being admitted due to a specialized services determination. A SFY 2008 cost for 8,240 PASARR Level II screens was $1,714,784.

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

**Nursing Home Relocation Planning**

Wisconsin received two grants from the Centers for Medicare and Medicaid Services; a Real Choice Systems Grant and a New Freedom Initiative Grant. The DMHSAS has identified key nursing facilities that have significant numbers of residents with mental health diagnosis and that have expressed willingness to jointly plan with county staff for community placement. One goal is to ensure that the system incorporates best practice models that include comprehensive, recovery-based assessment and planning. Relocation involvement at the time of facility closure or downsizing is also actively pursued as a time to provide technical assistance regarding community placement options. In January 2007 Wisconsin received approval of its proposal for a Money Follows the Person Demonstration Grant.

The Community Opportunities and Recovery (COR) is a relocation waiver for people living with serious severe mental illness and a co-occurring physical disability in a nursing home and want to move to the community. Due to the amount of time it took to develop the governing policies, procedures and the corresponding manual materials for this new 1915 (c) home and community based services waiver, the effective date was amended with the Centers for Medicare and Medicaid Services (CMS) to January 1, 2008.

Numerous meetings and contacts were made with those counties who had not already transitioned to Family Care. (Once Family Care is implemented in a county, the COR waiver is wrapped into it and no new participants are enrolled in COR.) During 2008, Dane County successfully implemented the COR waiver and relocated four individuals from their county operated nursing home. None of these four individuals were eligible for the Money Follows the Person Project.

**Institutional and Inpatient Services**

The Wisconsin public mental health system recognizes the need for people with serious and persistent severe mental illness to live in and receive mental health services in their community. The community mental health system strives to provide an array of services to the consumer to reduce the need for inpatient treatment and reduce the disruption caused to the consumer and family by hospitalization. Discharge planning and aftercare service system coordination with the community mental health system are required to be initiated on the day of the consumer’s admission, and are key to keeping the length of the hospital stay to a minimum; assuring minimal re-admission and promoting recovery.

Psychiatric hospitalization in Wisconsin occurs in the following five settings: state mental health institutions, county mental hospitals, two veteran's administration hospitals, private psychiatric hospitals, and general medical/surgical hospitals. DMHSAS has administrative management of the two state mental health institutes: Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute in Winnebago. These facilities provide specialized, acute treatment to children/adolescents, adults, older adults and forensic mental health consumers with the long-term goal of reintegration into the community. The institutions provide training and consultation as requested to community-based programs.
Counties have a general statutory responsibility and a fiscal incentive to provide comprehensive community programs. If a client between the ages of 22 and 65 is admitted to a private or state psychiatric hospital, then MA reimbursement is not available, therefore the county is responsible for paying for an indigent patient’s care in that facility. If a county uses inpatient facilities extensively, it will be expensive. In contrast, if a county chooses to develop CCS or CSP for its adult residents with severe and persistent severe mental illness, then it may use saved inpatient dollars for community services. Table 8 outlines the trends in the average length of stay of patients who have a mental disease or disorder of all ages by funding source for all Wisconsin hospitals (general and psychiatric).

It should be noted that the data for the categories of self-pay and other/unknown are based on small numbers of persons compared to the other payer categories (e.g., the 42.75 days for those "other" payers in 2001). Therefore, outliers in the data tend to skew the average length of stay.

### Table 8

<table>
<thead>
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<tbody>
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<td>Medicaid</td>
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<td>33.89</td>
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<td>6.8</td>
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</tbody>
</table>

**TOTAL LOS**


Source: March 2009 - Bureau of Health Information, Division of Health Care Access and Accountability

*The total average LOS cannot be computed by averaging each column of figures due to variance in the number of people in each category.

While generalizations must be taken with caution, from the standpoint of the Major Diagnostic Category of mental diseases and disorders, the data trend generally portrays a sustained drop in the average length of stay from throughout the ten-year period.

**State Mental Health Hospitals’ Bed Capacity and Use**

Chart 1 shows the number of “staffed” beds for the state’s two mental health hospitals and Chart 2 shows the average daily census at the two state hospitals. Table 9 shows the data for these two charts. As the average number of “staffed” inpatient beds has decreased in the last 10 years (Chart 1), the average daily census has remained stable (Table 9) indicating a more efficient use of the inpatient beds in the state. The state plans to work towards further reduction in the use of these hospitals particularly for children through the hospital diversion program. Both children’s staffed state psychiatric inpatient beds and inpatient utilization have steadily decreased since 1995.

Table 9 does not indicate a significant reduction in the use of state-owned hospital beds for adults, but it does indicate that children's beds were reduced by 20 in 2008. The utilization rate is low for a state population of over 5.5 million persons. This is because there has been a decrease in private general psychiatric beds throughout Wisconsin causing inpatient bed shortages due to
current economic short falls, staff reallocations, and shortages in the workforce. Other challenges center around the point at which the reduction of inpatient psychiatric beds becomes a negative factor on the ability of a comprehensive community-based system to provide timely and age appropriate access to consumers across the life span. A delay in access to inpatient services can mean that the severity and duration of the illness may be increased, a longer hospital stay is required, and there is greater demand for specialized mental health services, medications and other health care treatment.

Comparing length of average stay (LOS) between all Wisconsin Hospitals and the State Mental Health Institutes reflects some differences between payer types. In Chart 4, over the past five years in Wisconsin hospitals, the average LOS decreased slightly for Medicaid recipients from 11 to 10 with and decreased slightly for Medicare recipients from 11 to 10 days. Also, in Wisconsin hospitals there was a notable spike in the average LOS for other payer types at 35 days between 2004 and 2005. For the Mental Health Institutes, Medicaid and Badger Care recipients' average LOS went down from 50 days to 30 days. Notably, Medicare recipients had an average LOS of 130 days in 2004 and decreased by about ½ in 2007. Generally, the average LOS tended to be higher for the State Mental Health Institutes than in all Wisconsin hospitals.

Chart 5 provides the number of psychiatric beds in Wisconsin hospitals in 2009. In 2009, the number of psychiatric beds available is 2045, the number staffed is 1631, and the average daily census for psychiatric beds in Wisconsin hospitals is 1103. As of June 2009, there are 4,776 beds in 414 community-based residential facilities, and 1,937 beds in 501 state licensed adult family homes that potentially could serve persons who have a mental illness.
Chart 2:
Average Daily Census at State-operated Psychiatric Hospitals 1993 to 2008

Chart 3
Average Length of Stay for Cy's 2003 - 2007 for MMH I & WMH I (by Expected Payer Source)
This information is drawn from responses to the 2007 Annual Survey of Hospitals and the Fiscal Year 2007 Hospital Fiscal Survey, and represents each hospital's pages from the Guide to Wisconsin Hospitals, Fiscal Year 2007, Wisconsin Hospital Association Information Center, and 2009 data from the Division of Quality Assurance. Sample Size: 50 hospitals (including the SMHIs)

Note: Some of the hospitals that report beds staffed and avg. census do not have a separate, distinct AODA or psych unit.
Table 9:
State-operated Psychiatric Inpatient Hospital Utilization (Average Daily Census)
(State Fiscal Year 1998-2007)

| State Psychiatric Inpatient Hospital Beds (staffed) – State Fiscal Year 1998-2007 |
|--------------------------------------|---|---|---|---|---|---|---|---|---|---|---|
| Adult Forensic                        | 326  | 326  | 322  | 306  | 301  | 301  | 301  | 301  | 298  | 298  | 298  |
| Adult Psych                           | 91   | 91   | 91   | 85   | 109  | 109  | 109  | 105  | 104  | 107  | 107  |
| Child Psych                           | 125  | 125  | 125  | 127  | 94   | 84   | 84   | 94   | 84   | 84   | 64   |
| Substance Abuse                       | 25   | 25   | 25   | 37   | 37   | 37   | 37   | 37   | 37   | 37   | 37   |
| Total                                 | 563  | 563  | 563  | 555  | 541  | 531  | 527  | 536  | 526  | 526  | 506  |

DMHSAS INFORMATION (2007)

| State Psychiatric Inpatient Hospital Utilization (Average Daily Census) – State Fiscal Year 1998-2007 |
|--------------------------------------|---|---|---|---|---|---|---|---|---|---|---|
| Adult Forensic                        | 283  | 285  | 283.1| 293.1| 294.6| 296  | 288  | 290.8| 290.6| 284.7|
| Adult Psych                           | 75   | 84   | 84.3 | 86.4 | 93.4 | 103  | 89.9 | 99.7 | 106.6| 102.4| 111.0|
| Child Psych                           | 96   | 97   | 97.1 | 104.7| 85.5 | 70.6 | 75.2 | 71.9 | 67.1 | 68.3 | 53.4 |
| Substance Abuse                       | 20   | 34   | 33.7 | 32.6 | 33.4 | 35.0 | 34.5 | 34.9 | 32.8 | 32.3 | 29.0 |
| Total                                 | 484  | 500  | 498.2| 516.8| 506.9| 504.6| 497.9| 494.5| 497.3| 493.6| 478.1|

DMHSAS INFORMATION (2007)

**Employment Services**

**Peer Specialist Development**

With funding from the Medicaid Infrastructure Grant given to the Department by CMS, the Division has been able to give a contract to a local Independent Living Center to hire a mental health consumer to assist the Department in the creation of a system for Wisconsin to ensure that peer specialists meet CMS standards for Medicaid billing in the major community programs in Wisconsin. Capacity and authority to hire peer specialists already exists for the Crisis Programs, CCS and CSP. What was lacking was a job description, competencies and approved training to ensure quality peer specialists in Wisconsin programs. In 2007 a consumer/advocate committee of the Recovery Implementation Task Force was created to develop the peer specialist program. To date, a job description and competencies have been developed and approved, a draft state examination for peer specialists is in progress and by the end of this year it is expected that the examination will be established and state wide data base of trained and certified peer specialists will exist. In addition 30 peer specialists were trained by the Depression and Bipolar Support Alliance (DBSA) in April 2008, and most of those individuals now have employment.

**Employment Services for Adults**

Adults with severe mental illness in Wisconsin meet their employment need in a variety of ways, but not always with success. Many individuals seek employment on their own. Others use mainstream services such as temporary employment agencies or the services of the state’s network of over 60 job centers funded under the Workforce Investment Act. While these avenues
may result in securing employment, some individuals with severe mental illness may have difficulty maintaining employment due to job stress and variations in the status of their disorder.

The Department of Workforce Development (DWD) as the primary agency responsible for employment services has received funds from the Recovery and Reinvestment Act. Guidelines for the use of these funds have not yet been received for all DWD Divisions. The Division of Vocational Rehabilitation (DVR) anticipates receiving approximately ten million dollars to be allocated within two years. Fifty percent of these dollars are expected to be available by the end of March 2009. Guidelines for use have not been received, but DVR is planning to utilize Recovery and Reinvestment funds to make DVR services available to more consumers who have been waitlisted, and to possibly provide employment to individuals who will provide vocational rehabilitation services.

In January 2009, DVR had sufficient funding to invest in employment plan services for an average of 12,373 individuals on a daily basis. At the end of February 2009, the Division had more than 6,400 eligible applicants waitlisted for DVR services. By July 2010, DVR projects building their caseload from the current level of 12,400 to a daily average service capacity of 14,656 individuals. This is an increase of more than 2,250 individuals a day receiving DVR services.

DVR’s purpose is to assist all persons with disabilities regardless of the type of disability to achieve their employment goals by removing barriers to their full employment. With this clear statement of financial support for our work from these federal funds, DVR will be able to provide employment services to people who would otherwise need to remain on a waitlist for much longer.

A large number of mental health consumers receive long-term employment supports via CSP, CCS and community rehabilitation programs around the state. These day services, sheltered employment, supported employment and other community employment programs are funded by a combination of state and private funding sources. While long-term supports may increase the employment success rate for persons with chronic and persistent mental health conditions, there may be a wait list for this level of support in some counties.

Employment options for persons with serious and persistent severe mental illness can be challenging. The complexities of eligibility, fragmentation of services and sources of information around work, earned income, and access to critical health care supports (see description the Medicaid Purchase Plan below), have traditionally made employment outcomes poor for citizens with disabilities. Wisconsin offers a number of programs designed to help people with disabilities, including severe mental illness, seek and retain employment.

**Disability Program Navigators**

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

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

**Division of Vocational Rehabilitation (DVR) Supported Employment Pilots**

In 2004-05, DVR and DMHSAS negotiated a Memorandum of Agreement to establish three local project sites to implement Supported Employment for persons with serious severe mental illness. While the previous project was restricted to CSP, this project implemented Supported Employment with CSPs plus targeted case management and other mental health programs in a different configuration in each county. Projects successfully enrolled 48 participants. Sites received training in the Supported Employment fidelity scale developed by SAMHSA and Supported Employment assessment techniques, job development, and other issues. Training and technical assistance was completed on June 30, 2007. Local community rehabilitation programs provided the vocational specialist staff to team with treatment staff in the process. The model being employed was based on evidence-based practices as identified by SAMHSA. The pilot was successfully implemented and the funding has ended.

**Wisconsin Pathways to Independence**

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

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

The Social Security Administration has granted WPTI demonstration authority that permits selected participants to earn over the usual limit of the Social Security disability program. Twenty-two community agencies around the state began enrollment in this waiver starting late summer 2005, with four of these agencies serving primarily people with severe and persistent severe mental illness. In addition, 14 of the other contracted agencies actively work with individuals living with severe mental illness. The contracted agencies are required to ensure that potential participants meet the eligibility requirements and connect them with the necessary services/resources (specifically benefits counseling and employment supports).
Wisconsin, using grant funds allocated to OIE, is involved in professionalizing Peer Specialists by developing a certification exam and process and a professional association of Peer Specialists, and implementing evidence based practices in supported employment for people with severe mental illness throughout the state. The peer mentors are trained, certified and work closely with their peers in the process of recovery through employment. A new effort in Wisconsin has been established between the Department of Instruction and the Wisconsin Technical College System to train individuals with behavior disorder diagnosis in specialized employment fields, while they are in high school. The intent is to improve graduation rate and secure employment prior to the time that they might have more significant symptoms so that they are less likely to need benefits.

Services for Special Populations

Wisconsin Forensic Programs and Corrections

State forensic programs serve persons who are to be assessed for competency to stand trial, who have been committed for treatment to competency, or were found by a court of law to be not guilty by reason of mental disease (NGI) or defect of a felony or misdemeanor. Individuals found NGI by a court may be placed directly into the community under Conditional Release or committed for institutional care. If committed for institutional care, the person may then petition for Conditional Release every six months. A Conditional Release requires community placement and mental health treatment with coordinated supervision by a contracted case manager and a probation and parole officer who has received training in mental health issues.

Inpatient admissions at the two state mental health institutes have gone from 2,496 in 2004 to 3,146 in 2008. Of those totals, Forensic admissions for 2004 were 355 and in 2008 were 524. For the past three years, the adult units have been over 90 percent capacity for all but two months; many months have been over 100 percent capacity.

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

The Conditional Release program not only produces direct cost savings, but significant indirect cost savings and positive outcomes for the clients and society:

- Over the past year only two percent committed a new crime (one percent a non-violent offense and one percent a violent offense);
- Only 9.6 percent were revoked (versus 38 percent for similar individuals exiting corrections without this program);
- 36 percent achieved competitive employment; and
- 74 percent were living independently.
Progress has recently been made in reducing the size of the Forensic wait list. From a high of 30 or more at various times over the past year, the numbers have come down to a more manageable range of around ten. This has reduced the wait for any particular individual and there have been no complaints from the courts or jails. The Institutes have been doing a good job of arranging admissions as soon as a bed is vacated and the court liaison staff have been successful in getting hearings set for those restored to competency.

Starting this past year, outpatient competency restoration became an option and a program to accomplish this was established. This program has been picking up additional referrals and has been successful in accomplishing restoration in an outpatient setting. The Wisconsin Resource Center has also been able to take individuals within the corrections system who were committed for competency restoration based on crimes occurring while in prison. These individuals would previously have had to come to an Institute bed. All of these factors have enabled the Department to manage the list effectively and to go into 2009 with a relatively small number of names on the list.

The Wisconsin Resource Center serves persons in the Wisconsin prison system with a severe and persistent severe mental illness. These persons have been convicted, pled guilty, or pled no contest to a crime and are serving a prison term. Those persons whose mental health needs cannot be met in the prison setting are transferred for specialized mental health services to the Wisconsin Resource Center.

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

The Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health continues to facilitate coordination between the Department of Corrections, Department of Health Services, Division of Vocational Rehabilitation and the Social Security Administration by holding 8 meetings per year involving key personnel from each agency. The Committee is addressing a broad spectrum of issues that are directed at: 1) diversion; 2) improving conditions of individuals with MI in our jails and prisons; and 3) significant re-entry issues that will assist them in successful re-entry back into our communities.

Specific initiatives:
- The Committee was instrumental in the creation of a Department of Corrections Administrative Directive establishing a benefits application process to expedite the availability of medical insurance and cash benefits shortly following release from the State prisons.
- A work group of the Committee collaborating closely with the Social Security Administration has modeled a system whereby Social Security knows on a timely basis, all individuals on Social Security Income benefits incarcerated in Wisconsin jails. This allows the benefits to be terminated so that following time served the individual does not have a pay back problem. The model also included timely reinstatement of benefits upon release. Meetings were held in all “jail regions” of the State to spread the use of the model.
- The Committee continues to recommend expanding the use of a successful “Conditional Release” program in use for “Not Guilty for Reason of Insanity” discharges from our State Mental Health Institutes. It appears a “pilot program” will be started shortly.
The Committee is now seriously considering a state wide analysis of the gaps in mental health treatment in our 60 some jails that are each administered by local sheriffs and administrators—each with their own individually developed policies. Wisconsin's jails have many of the same problems that were reported in an extensive study conducted in North Carolina. The Committee has studied the success of the Kentucky triage approach of providing professional mental health guidance on demand from all State jails on a 24/7 basis through a centralized communications system.

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

**Veterans’ Mental Health Services**

Since October 2001, approximately 1.64 million U.S. troops have been deployed for Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) in Afghanistan and Iraq. Early evidence suggests that the psychological toll of these deployments — many involving prolonged exposure to combat-related stress over multiple rotations — may be disproportionately high compared with the physical injuries of combat. In the face of mounting public concern over post-deployment health care issues confronting OEF/OIF veterans, several task forces, independent review groups, and a Presidential Commission have been convened to examine the care of the war wounded and make recommendations. Concerns have been most recently centered on two combat-related injuries in particular: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). With the increasing incidence of suicide and suicide attempts among returning veterans, concern about depression is also on the rise.

A recent study by the RAND corporation studied war related mental health problems experienced by veterans and made recommendations. RAND conducted a comprehensive study of the post-deployment health-related needs associated with these three conditions among OEF/OIF veterans, the health care system in place to meet those needs, gaps in the care system, and the costs associated with these conditions and with providing quality health care to all those in need. Among their recommendations is that effective treatments documented in the scientific literature — *evidence-based care* — are available for PTSD and major depression. Delivery of such care to all veterans with PTSD or major depression would pay for itself within two years, or even save money, by improving productivity and reducing medical and mortality costs. Such care may also be a cost-effective way to retain a ready and healthy military force for the future. However, to ensure that this care is delivered requires system-level changes across the Department of Defense, the Department of Veterans Affairs, and the U.S. health care system.

The DMHSAS continues its efforts to collaborate with the Veteran’s Administration on increasing access to mental health services for veterans. The availability of mental health services for veterans is becoming a higher profile issue with the increasing number of soldiers returning home from Iraq and Afghanistan. In Madison, Wisconsin, the Veteran’s Recovery Coordinator is active in the Recovery Implementation Task Force (RITF), as well as the Adult Quality Committee of the Mental Health Council. Also, a Peer Specialist provides support at the
Veteran's Administration Community Support Program. An additional Peer Specialist from the Veteran's Administration is an active participant in the RITF. The emerging partnerships with the Madison Veteran's Administration have enhanced our statewide recovery network.

The DMHSAS will continue 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 set up of tele-medicine. The DMHSAS and Regional Area Administration Offices of DHS will assist in informing counties of the availability of these services and informing providers of the special needs of returning veterans.

**Housing Services**

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

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

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

Shelter Plus Care is another HUD-funded program. It provides rental assistance for hard to serve homeless individuals with disabilities, in connection with services funded from sources outside of the program. Milwaukee, Dane, Racine and Rock County have Shelter Plus Care programs. Shelter Plus Care is “permanent housing,” and the rental assistance is available to the participants.
on an ongoing basis as long as an amount of services, equal to the amount of rental assistance, is provided from other sources.

HUD provides Supportive Housing dollars to fund seven innovative, permanent supportive housing projects that serve individuals who have serious severe mental illness or HIV/AIDS. The Department of Commerce has initiated three projects following the Shelter Plus Care model using HUD HOME Tenant Based Rental Assistance funds. The first of these projects is in La Crosse where the Coulee CAP organization has secured matching services from the La Crosse County CSP. The other two projects are in Rock County and Brown County, respectively, and have a commitment by the area Community Support Programs to provide reliable matching supportive services. In 2007, the Waukesha Housing Authority applied for funds to support an additional Shelter Plus Care program, to address housing needs in the Waukesha area.

*Projects for Assistance in Transition from Homelessness*

Projects for Assistance in Transition from Homelessness (PATH) funding continues to be administered through The Department of Commerce, Division of Housing and Community Development, Bureau of Supportive Housing. Also continuing is a Memorandum of Understanding between DHS and the Department of Commerce that contains 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 will 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 include: 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 of these people.

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 these people not to stay in one place very long often impedes simply having application submitted. 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 have developed SOAR training teams who have attended national training and are qualified to teach service providers to utilize the SOAR model to assist their clients in applying for SSI/SSDI. In 2008, close to 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 understands 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 continued 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 being used to hold a Wisconsin PATH Conference. Over 50 service providers representing five PATH-funded and more than 20 non-PATH-funded agencies will be attending the conference. The keynote speaker for the event is a nationally known speaker who will provide 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) can assist 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 people who are homeless and mentally ill are just one of the target populations that grantees can serve through TBRA, it seems 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 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

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.

- 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.
Educational services

The provision of assistance, supports, and rehabilitation services to individuals to meet their educational goals (supported education) and ultimately their vocational goals should be a primary function of the community based psycho-social programs beyond outpatient services. Both the CSP and CCS programs have education as an assessment domain requirement. Training has been available to staff on how to provide supported education services at the annual Vocational Services Conference. Practitioners who are experienced in provision of these services from within and outside of Wisconsin were trainers at this event. Individual case consultation has been available to programs participating in both CSPs/Division of Vocational Rehabilitation Pilots and the Pathways to Independence Projects. As previously stated, Disability Navigators are now working to facilitate youth transitioning (aging out) from schools to secure employment and economic self-sufficiency through schools and the CESAs.

Barriers to participation in educational experiences would be funding and accommodation issues. For individuals with very small incomes, participation would be dependent on funding from an outside source. The most common source of support would be from the DVR funding. However, this funding would be contingent upon the educational experience leading directly to employment.

Substance Abuse Services

Data on Adult Substance Abuse

Wisconsin recently received a Strategic Prevention Framework-State Incentive Grant (SPF-SIG) to implement an epidemiological study which will provide data on which to base system of care development and evidence-based practices for substance abuse treatment. Wisconsin’s 2008 “Epidemiological Profile Report” provides indicators on the consumption of alcohol and other drugs and related consequences for adults and youth. Detailed below are the initial results of the study.

Consequences of Alcohol and Other Drug Consumption

Many types of mortality, morbidity, and dangerous criminal behaviors have been linked to the use of alcohol, tobacco and other drugs. In Wisconsin in 2006, at least 1,678 people died, 5,654 were injured, and 88,000 were arrested as a direct result of alcohol use and misuse. Given Wisconsin’s high rate of alcohol consumption, it is not surprising that the rates at which Wisconsin experiences the consequences associated with alcohol use also tend to be higher than the national average. Rates of alcohol dependence, alcohol abuse, and alcohol-related motor vehicle fatalities are higher in Wisconsin than in the United States. Wisconsin has one and one-half times the national rate of arrests for operating while intoxicated and more than three times the national rate of arrests for liquor law violations.

From 1999 to 2006, Wisconsin's age-adjusted rate of drug-related deaths increased. The statewide rate of drug-related hospitalizations has also increased in recent years. Crime associated with illicit drug-related hospitalizations has also increased in recent years. Crime associated with illicit drug use also negatively affects the community. Wisconsin's rate or arrests for drug law violations remains lower than the national average but has increased since 1997.
**Drinking and Driving**
Wisconsin has the highest prevalence of self-reported drinking and driving of any state in the nation. Based on combined data for the years 2004-2006, an estimated 26 percent of current drivers age 18 and older in Wisconsin drove under the influence of alcohol in the past 12 months. This was markedly higher than the percentage among all current drivers in the nation (15 percent).

**Alcohol Consumption**
Wisconsin has arguably the highest prevalence of alcohol use in the United States. In recent years, the percent of high school students who initiated alcohol use before age 13 has been similar to the national average and decreasing. However, current use of alcohol among both youth and adults is the highest in the country.

In 2007, Wisconsin high school students reported the highest rate of current alcohol use (49 percent) among all reporting states, and the third highest rate of binge drinking (32 percent). Among adults in 2006, Wisconsin reported the highest rates of binge drinking (24 percent), current alcohol use (69 percent), and heavy drinking (eight percent) in the country. Per capita consumption was also among the highest in the nation (2.92 gallons per person in 2005). Compared to the United States as a whole, Wisconsin had higher rates of underage drinking (ages 12-20), underage binge drinking, and drinking among women of childbearing age.

**Dependence or Abuse**
Dependence and abuse are direct consequences of alcohol misuse. From 2002 to 2006, the reported rate of alcohol dependence or abuse ranged between nine percent and 11 percent of the Wisconsin population age 12 and older compared to a steady eight percent nationally. In Wisconsin, young adults ages 18 to 25 had a notable higher rate of alcohol dependence or abuse than other ages.

**Other Drug Consumption**
The use of drugs other than alcohol remains a problem in Wisconsin. As a whole, consumption patterns of illicit drugs in Wisconsin mirrored national trends with few exceptions. One notable trend was in the use of marijuana. In 1997, the prevalence of both lifetime and current use of marijuana were lower than the national average. Over the next four years, however, these measures rose until they were nearly identical to the national averages. Since 2001, both lifetime and current use of marijuana in the United States and Wisconsin have decreased at similar rates. In the United States as a whole, illicit consumption of prescription drugs among youth has been rising. Data on state-specific rates were unavailable.

**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

The Wisconsin Initiative to Promote Healthy Lifestyles Administered by Department of Family Medicine School of Medicine and Public Health University of Wisconsin-Madison, is Wisconsin's SBIRT program. Many people engaging in risky and problem drinking and drug use can be helped by evidence-based, cost-effective Screening, Brief Intervention, and Referral to Treatment services. Studies show that SBIRT often identifies and effectively addresses risky behaviors before the problems get worse.

In Wisconsin, this service is being implemented by the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), funded by SAMHSA through July 2011. Since March 2007, the service has been offered to all patients 18 and older in participating primary care settings.
• A Brief Screen, consisting of four brief questions on alcohol and drug use and additional questions on other health behaviors, is administered to each patient once a year as part of any health care visit. The screen identifies people who are at risk for alcohol and drug abuse even at an early stage.
• Patients who score positive meet with on-site health educators—who are trained and supported by WIPHL—to discuss their drinking or drug use and agree upon changes.
• This Brief Intervention consists of one to three consultations taking about 20 minutes each. For many patients, that service is enough to help them significantly decrease their alcohol and drug use, studies show.
• The health educator and patient may agree that a Referral to Treatment for more intensive care—outpatient or residential—is needed. Costs may be covered by WIPHL.
• WIPHL serves patients from a range of ethnic and socioeconomic backgrounds. Health educators are trained in cultural competence.
• The program uses motivational interviewing, in which patients are helped to identify and strengthen their own motivations for change. Counseling is nonjudgmental and respectful of the patient’s own degree of interest and readiness.

Medical and Dental Services

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 certain other children and pregnant women. Without Medicaid, these people would be unable to receive essential services or would receive uncompensated care.

Medicaid Purchase Plan

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.

Under MAPP, participants:
• receive the same health benefits offered through the Medicaid (MA) Program;
• may earn more income, than another group of Medicaid (MA) recipients, without the risk of losing health care coverage; and
• are allowed increased personal and financial independence through saving opportunities, known as Independence Accounts.

Dental Services

Access to dental services continues as an identified struggle for low-income consumers, as well as for those consumers and families who are MA recipients in the state. Dental care services received increased focus during contract negotiations with HMOs to increase access, as only a few HMOs cover dental services. This is a particular issue with detrimental health outcomes for adults with serious and persistent severe mental illness, due to the side effects of many psychotropic medications.
Case Management Services

Case Management

As noted previously, case management is an integral part of Wisconsin's services. All of Wisconsin counties provide some level of case management for persons who have a serious severe mental illness. Case management is a general approach to coordination of services from multiple systems of care for mental health consumers.

Targeted Case Management

Targeted case management is a mechanism for coordinating and arranging services and is a covered service through Medicaid. It includes ensuring comprehensive assessment and regular reviews of assessment and recovery plans, follow-up and monitoring of referrals, coordination of services available at the local level, and coordination of crisis services. Each county provides case management, which is a linkage connecting individuals to services provided by multiple mental health, housing, or rehabilitation programs in the community. For MA recipients, counties may bill the MA program for targeted case management services, and the county provides the match to FFP from non-federal funds.

Services for persons with co-occurring (substance abuse/mental health) disorders and other activities leading to reduction of hospitalization

DHS continues to seek out the latest research on treatment, prevention, and recovery, and to disseminate information to the substance abuse field for improvement in treatment outcomes. DHS has partnered with the Prairie Lands Addiction Technology Transfer Center. This partnership brings national experts to Wisconsin providers in teleconference training by researching and incorporating the latest science into its service delivery system. Wisconsin is working hard to support effective prevention and treatment programs by improving the use of evidence-based practices and putting resources behind them. Wisconsin has had an Access to Recovery grant program in Milwaukee called "WiserChoice." This voucher program provides substance abuse treatment funding for use with evidence-based treatment and supportive services. This grant has brought $22 million federal dollars for services and facilitated a comprehensive substance abuse system which includes: a voucher based treatment provider network; recovery support; and faith based provider services. The Department of Health Services continues to seek out additional federal and other resources to provide additional services.

DMHSAS is focusing efforts to provide increased education and outreach to providers on best-practice integrated treatment services. The fourth DMHSAS-sponsored conference on integrated services was held in fall 2008. All of the DMHSAS conferences since 2005 have had a track for professional development in integrated services. Many county agencies are encouraging their mental health staff to obtain the substance abuse counselor specialty for community services and the Department of Regulation and Licensing and DMHSAS are working together to promote training for the specialty that is accessible and flexible.

The CCS benefit was designed to provide integrated mental health and substance abuse services. County programs are just beginning to focus on developing their substance abuse services array.
Administrative Code Regarding Dual Diagnosis Services

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

In 2007, the percentage of adults served by the State Mental Health Authority (SMHA) who also have a diagnosis of substance abuse was 18 percent. In the same year, the percentage of children served by the SMHA who also had a diagnosis of substance abuse was four percent. These individuals are served through the county mental health system and tracked through the Human Services Reporting System (HSRS), therefore are only the proportion of individuals with dual diagnoses served through the county.

County-Based Dual Diagnosis Services

Wisconsin has a county-based system for the delivery of public mental health services. In general, the mental health and substance abuse systems are run separately. Many counties integrate mental health and substance abuse services, however. Each county has its own model, ranging from dual certification of some of its providers to collaboration between mental health and substance abuse providers. Some have programming in place specifically to address individuals with dual diagnoses, while others address each client on an individual basis and involve either type of clinician when indicated. Below is a sampling of Wisconsin counties with descriptions of their approaches to addressing individuals with both mental health and substance abuse issues:

Lincoln, Langlade and Marathon Counties
Lincoln, Langlade and Marathon Counties have salaried staff that provide mental health and substance abuse services. In Lincoln County, three of the six therapists on staff are currently dually certified, with one more scheduled to obtain dual certification by March of 2009. The director of the mental health center is also dually certified. The center’s staff meetings are attended by all therapy staff with the psychiatrist and the director, which provides an opportunity to integrate treatment not only for substance abuse and mental health, but also for multiple family members. The initial staffing issues/treatment recommendations and reviews are addressed in subsequent staffings.

Columbia County
Columbia County contracts with the Pauquette Center to provide mental health and substance abuse services for their clients. In general, the Pauquette Center has both licensed mental health professionals and certified substance abuse counselors on staff. The Pauquette Center utilizes a peer review style of supervision. This allows clinicians to obtain consultation from providers with particular areas of expertise.

The approach the Center takes to delivering integrating services for individuals having co-existing issues includes:
• Treat both problems simultaneously.
• Assist the client in recognizing the connection between the mental health and the addiction problem.
• Recognize and use the similarity of techniques that can address issues such as depression and/or anxiety as well as addiction.
• Utilize a non-judgmental approach.
• Utilize a motivational-based treatment style.
• Recognize that certain medications should not be used with individuals with alcohol/drug issues.
• Monitor compliance with medication.
• Recognize that treatment is likely to be long-term, and assist the client in recognizing this fact.
• Consult closely with other providers the individual is working with.

Therapists at the Center assess clients for mental health, substance abuse and social service issues regardless of the reason given for referral. A client history is taken, short and long term goals are established, and clients receive therapy and education to meet their goals. Therapy may include some aspects of education regarding risks to personal and public safety (especially associated with substance use) and the short term and long term effects of substances on personal and family health. Clients may also be referred to one of the agency psychiatrists for an evaluation regarding the use of medication if indicated.

**Douglas County**
Douglas County contracts with HCD Douglas County for both mental health and substance abuse services. Until about a year ago, these services were provided independent of each other. If someone was dual diagnosed, they would have an outpatient therapist, and may also have a substance abuse counselor or treatment. At that time, services were provided with minimal contact between the two treatment teams.

Presently, mental health and substance abuse services are integrated in the County. HDC has hired a dually certified clinician, and hopes to hire additional dually certified individuals. Additionally, clinical staffings now integrate mental health and substance abuse staff and integrated treatment planning. Also, both types of providers are now physically located in the same building. An example of successful integration of services includes the completion of substance abuse treatment of an individual with schizophrenia in 2008. Community Support Staff who case managed the individual worked with treatment staff to educate them about the client's symptoms and medication management and reported it was an important learning experience regarding how to coordinate the two types of services.

**Fond du Lac County**
Fond du Lac County providers coordinate mental health services with outpatient substance abuse services. Examples of these services include: community support groups such as NA/AA and dual diagnosis support groups for individuals with co-occurring disorders; particularly those who are on medication. Individuals with substance abuse and mental health issues attend a primary outpatient program that addresses the needs of individuals who have side effects or underlying symptoms of severe mental illness that may not be stabilized with medications. Additionally, providers provide crisis intervention services and in the event of a relapse, detoxification services are contracted. Mental health providers coordinated relapse prevention, family treatment services and aftercare. On-going contracts/staffings are made with the mental health provider and
substance abuse staff. Staff are responsible for obtaining specialized training in working with individuals with mental health and substance abuse issues.

Also, the county residential treatment providers employ an addictionologist/psychiatrist to monitor mental health concerns and medication management. Staff are also trained in pharmacology in order to understand the needs of the mentally ill/substance abuse consumer. Weekly staffings/consultations are held by substance abuse/mental health specialists. The addiction facilities also encourage consumers to participate in mental health support groups and the community based Friendship Corner (drop in center for persons with severe mental illness).

**Milwaukee County**

Milwaukee provided two examples of county run facilities which address individuals with co-occurring mental health and substance abuse issues. Bell Therapy, Incorporated, a subsidiary of Phoenix Care Systems, currently operates nine facilities in Milwaukee County. One of these facilities, Belwood, is a licensed 46 bed community based residential facility (CBRF). Forty-one of these beds are contracted with the Milwaukee County Behavioral Health Division. Consumers who are referred to Belwood are most commonly being discharged from an acute care psychiatric facility and continue to experience positive symptomatology and display a high level of psychosis. As a result, consumers referred to Belwood continue to require a higher level of staff supervision and more intense assistance engaging in and completing basic daily living skills. Belwood works with consumers who are dually diagnosed with a severe mental illness and a history of alcohol and drug abuse. Belwood offers substance abuse support groups to consumers on a weekly basis, which includes a Drug and Alcohol Education Group. This group is designed to teach and instill concepts such as harm reduction, experimental abstinence, sobriety, and relapse prevention.

Another example of a center in Milwaukee County that addresses individuals with co-occurring issues is the United Community Center. It began in the late 1960s as an outreach program located in the heart of the Spanish-speaking community on Milwaukee's south side. From humble beginnings as a small teen center, the United Community Center has grown to a full service, state-of-the-art social services organization, including substance abuse residential treatment services. Each resident participates in approximately 20 hours of group therapy a week and one individual substance abuse session per week. If there are co-occurring mental health issues, the resident attends an additional individual session with the mental health therapist each week. These services are supplemented with "wraparound" case management, job skills training, interview/resume writing training, drug screening, health assessments and access to health care, daily living skills training, on-site psychiatric services, medication management and other supports. Hispanic cultural values and principles are utilized in the treatment approach with the residents and their family members, to help strengthen resident's efforts in achieving and maintaining sobriety.

**Wood County**

Wood County Unified Services provides a dual diagnosis group that is co-led by a licensed mental health therapist and an AODA counselor. In addition, there is an outpatient staff meeting once a month, where all AODA counselors and mental health therapists attend to discuss consumers in common and collaborate around treatment planning. When a client with a substance abuse issue that requires residential treatment is seen, they are referred to a contracted substance abuse provider. Wood County's contracted providers all have psychiatrists on staff. The client will be assessed for substance abuse and mental health issues and be referred to a psychiatrist if indicated. When a client with co-occurring disorders is discharged from residential treatment, substance abuse outpatient services are provided if indicated and an appointment with
on of the county mental health therapists is scheduled. Follow-up will also be done to make sure the client is connected with an outpatient psychiatrist for medication monitoring.

**Lafayette County**
Lafayette County is a small county agency with highly integrated services. If an outpatient therapist or substance abuse counselor treats a client with a co-occurring disorder, they consult with agency clinicians who specialize in those areas and work on a treatment plan that integrates the assessments and indicated services for that individual.

**Grant/Iowa Counties**
Grant/Iowa Counties do not have dually certified providers at their county mental health agency. Their mental health and substance abuse departments work closely together to provide appropriate services. Providers meet once a week to discuss cases, many of which involve individuals with dual diagnoses. The provider who does the initial assessment (substance abuse or outpatient mental health) determines the need for services and makes referrals for services. If there is a dual diagnosis present, the therapist and substance abuse provider always work together as a team to provide the best possible care. Both services are documented in the same chart, along with any psychiatric care where needed. The consumer is viewed as a "whole" person rather than as diagnosis.

**Waushara County**
County mental health and substance abuse providers are co-located in the same area of the mental health center. Consumers receive services from both types of providers simultaneously if needed. Providers are encouraged to work together and share information. Waushara has an Integrated Services Project in their agency. This operates with teams made up of formal and informal support persons. The goal is to identify consumer strengths, needs and resources. This program integrates mental health and substance abuse services in the wraparound plan where indicated. Waushara does not currently have any dually certified providers, but will soon have a licensed mental health provider with a sub-specialty in substance abuse.

**Waukesha County**
Waukesha County has an integrated clinic with a number of providers who are dually licensed. They also have dually licensed staff in their Community Support Program (CSP), Comprehensive Community Services (CCS), and inpatient hospital programs. Waukesha bases their service plans upon the presenting situation and assigns dually licensed staff as appropriate.

**Ozaukee County**
Most of the therapists at the mental health center in Ozaukee County are dually certified master's level, LPC or ICSW with a substance abuse specialty. Clients usually see a therapist for individual therapy and then may go to a primary treatment group, which is run by one of the therapists. As a County agency they hire staff that can see whoever walks through the door, therefore the director states it is not cost effective to use two therapists to see one person, nor is it necessarily the best approach to treatment. Ozaukee County laid off their CADC therapists and only hire dually certified master's level clinicians now.

**Marinette County**
Marinette County has two dually certified therapists that treat both substance abuse and mental health issues. The Adapt Clinic in Marinette County also treats substance abuse on an outpatient basis utilizing group and individual methodologies. They contract with Libertas for intensive outpatient services. If an individual has a co-occurring disorder, they see a substance abuse counselor and a mental health therapist to integrate treatment. If one of the dually certified
therapists is working with the individual, they provide an integrated approach addressing both disorders. The center also provides a group for ongoing stabilization and aftercare for dually diagnosed individuals.

**Pierce County**
Pierce County has both substance abuse counselors and mental health therapists. In addition, they have a psychiatrist on staff. In many cases, all of them are involved in providing services for a particular individual utilizing an integrated approach. The mental health center also provides a weekly group for individuals with severe mental illness, many of whom are also chemically dependent. The group is facilitated by one of the center's mental health therapists.

**Oneida County**
In Oneida County, mental health and substance abuse providers deliver integrated services at the KOINONIA Residential Treatment Center. Residents with co-existing alcohol and drug and mental health issues are clinically staffed weekly by the Medical Director, the mental health therapist and the substance abuse counselor. At the time of discharge from residential treatment, the individual is referred for mental health and substance abuse aftercare where indicated.

**Dane County**
In Dane County, the Department of Human Services contracts with the Mental Health Center of Dane County, Inc. (MHCDC) to provide both mental health services and alcohol/drug services. For many years the MHCDC maintained two separate programs, an Adult Mental Health Program and an Alcohol and Drug Treatment program. In 2006, faced with the growing number of consumers that were diagnosed with co-occurring mental health and substance abuse disorders, the MHCDC underwent a total reorganization to better integrate services.

The MHCDC created the "integrated Services Program" (IS). The IS brought together adult mental health, alcohol and drug, and child and family therapists to work together in teams. Each team had members that were dually certified and could treat both populations. Through case consultation and in-service presentations, the teams began to learn from one another. In-house Master's level social workers and counselors with AODA certification, created a state approved curriculum for AODA certification that non-AODA clinicians could attend, free of charge and during working hours. When the first cohort completes the curriculum, the MHCDC will have an additional 35 staff qualified to work with the dually diagnosed population.

**Washington County**
In Washington County, their CSP, CCS and TCM programs provide integrated treatment. They have two staff who are certified substance abuse counselors, one Clinical Supervisor and the other a Substance Abuse Technician. They offer a substance abuse group weekly and coordinate treatment with their contracted substance abuse treatment provider. The substance abuse technician offers independent living skills training, transportation and medication monitoring. Their outpatient clinic provides individual mental health services.

Washington County contracts with Genesis Behavioral Services to provide substance abuse outpatient and intensive outpatient services to adolescents and adults. They have gender specific and trauma informed services. Presently, they are working toward becoming a Matrix certified clinic. They are also dually certified for mental health outpatient. Mental health outpatient treatment is available only to those individuals who have the ability to privately pay or have insurance.
Tribal State Collaborative for Positive Change

The Tribal State Collaborative for Positive Change (TSCPC) was established in January of 2007 in order to provide a forum for the Wisconsin tribal mental health professionals, substance abuse coordinators and DHS personnel. The TSCPC is dedicated to improving the quality of behavioral health programming within tribal communities. In Federal Fiscal Year 2007, the TSCPC was awarded a $100,000 Mental Health Block Grant allocation for the purpose of initiating systems change within tribal behavioral health programs for the treatment of co-occurring disorders. The Sokaogon Chippewa Community is the fiscal agent for the TSCPS Systems Change Project.

During FFY 2008 the TSCPC experienced ongoing challenges in initiating systems change processes within their respective communities. As the TSCPC was a relatively newly formed workgroup, they experienced a core challenge of clearly defining roles responsibilities between tribal workgroup members, DHS representatives, the fiscal agent and the project coordinator hired by the Sokaogon Chippewa Community. In September 2008, due to under spending, the DMHSAS reduced the FFY 08 contract by $30,000. The Systems Change Project was again funded for FFY 09 with an allocation of $100,000 of MHBG funds. It has taken the workgroup a considerable amount of time to organize the project processes, as this is the Department’s first attempt to develop an inter-tribal project of this nature.

In 2008 the TSCPC conducted a specific needs assessment utilizing the COMPASS assessment tool. Eight of the eleven tribes completed the assessment. Five tribal representatives expressed a need for technical assistance in interpreting the results and initiating action steps related to prioritization of community goals for systems change. An educational training to help define co-occurring disorders, general awareness of challenges in creating system change, cultural competence and a strategic planning training occurred. More intense follow-up was also provided.

The TSCPC advisory group plans to continue working on a co-occurring systems change process and has invited strategic planning consultants to help facilitate the process within their respective communities.

Mental Health/Substance Abuse Services for 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 done by staff at DMHSAS. An important component of the DMHSAS planning work is the development of the Wisconsin Gero-psychiatry Initiative (WGPI). The WGPI began when a gero-psychiatrist, Dr. Tim Howell, initiated a collaborative with a group of persons interested in making gero-psychiatric 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 gero-psychiatrists 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 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 severe 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 has set aside money for outreach and treatment pilots in the 2008 and 2009 plan, and will team 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 need treatment but have never been diagnosed or treated for their severe mental illness because of stigma and self isolation.

The FFY 2008-2009 plan for development of mental health/substance abuse services for older adults includes:

- Partnership 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;
- Partnership 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);
- Partnership with MH and 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;
- Development and dissemination of web based gero-psychiatric training modules, using evidence based practices in connecting to and serving older adults, for use by case managers serving an older population;
- Development of an on-going gero-psychiatric 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
- Development of 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.

Services to Promote Recovery

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;
identifying and seeking funding to support Wisconsin's efforts to increase the community's access to trauma informed services;
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;
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creating training and educational opportunities for community members and service providers;
promoting agency policies and practices that are trauma informed;
identifying and seeking funding to support Wisconsin's efforts to increase the community's access to 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 will incorporate 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 will be utilized to facilitate the implementation of Trauma-Informed Care (TIC) within the public mental health and substance abuse services in the following ways:

- The Trauma Services Coordinator is a full time UW-Madison employee.
- A public relations firm will be hired to create a marketing strategy for the dissemination of Trauma Informed Care information.
- Provide a statewide TIC Conference.
- 150 Trauma Care Champions representing Wisconsin's human service systems will be identified and provided with initial training.
- The Trauma-Informed Care Advisory Board will hold six meetings.
- Three Trauma-Informed Care (TIC) special projects will be planned 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.
- DMHSAS staff will be trained in TIC.
Advocacy

NAMI

The National Alliance on Severe mental illness (NAMI) Wisconsin, Inc. has offered consumer and family education for over twenty-five years. NAMI Wisconsin is a grassroots organization with 34 affiliates serving an estimated 40 counties statewide and has membership of about 2,600. The organization represents mental health consumers, family members, mental health, and other professionals. NAMI Wisconsin maintains a database with over 5,000 contacts statewide. Individuals who self-identify as mental health consumers represent nearly 40 percent of the total NAMI Wisconsin membership. NAMI Wisconsin promotes recovery principles and incorporates recovery principles into all of their trainings and programs. Their mission is to improve the quality of life of people affected by severe mental illnesses and to promote recovery.

NAMI Wisconsin maintains a toll-free information line for family members and consumers, advocacy services, a NAMI Wisconsin website that includes education, advocacy, and service information along with the first informational pod cast of a state NAMI affiliate in the nation. NAMI also provides outreach programs to underserved populations including the development of college campus affiliates. NAMI Wisconsin is currently updating and revising its Family and Consumer Resource Guide. NAMI Wisconsin provides NAMI national training programs, including, In Our Own Voice, Family-to-Family, Peer-to-Peer, Support Group Facilitator training, NAMI C.A.R.E. training, and NAMI national’s new initiative, NAMI Basics. NAMI Basics is a program for families with young children with serious severe mental illness. NAMI Wisconsin is targeting up to 16 new trained teachers resulting new memberships among families with young children.

Disability Rights Wisconsin

Wisconsin’s protection and advocacy agency is Disability Rights Wisconsin (DRW), formerly the Wisconsin Coalition for Advocacy (WCA), which receives funding directly from the federal Center for Mental Health Services and from the DMHSAS allocation from the MHBG. The DRW is mandated to protect and advocate for the rights of individuals with severe 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 severe 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 severe mental illness, stigma, recovery, recovery-oriented services, trauma informed services, and access to appropriate services. In 2007, the Wisconsin State Legislature increased the MHBG award for protection and advocacy from $65,000 to $75,000. In 2008, DRW again received $75,000 in MHBG funds to implement its protection and advocacy activities.

Grassroots Empowerment Project, Inc.

Grassroots Empowerment Project, Inc. (GEP) is a state-wide non-profit organization that is controlled and directed by mental health consumers. Its mission is “to create opportunities for people with severe mental illness to exercise power in their lives.” Ninety percent of the Board of Directors and 100 percent of the staff of GEP are persons with severe mental illness. GEP is
funded with federal Mental Health Block Grant dollars. GEP received $454,000 from DHS in 2008. In addition, they received private donations.

In 2008, GEP held contracts with 10 separate and independent non-profit organizations that 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.

_Mental Health America of Wisconsin (formerly known as The Mental Health Association (MHA) of Wisconsin)_

Mental Health America of Wisconsin is the lead contracted agency for MHBG-funded prevention and early intervention activities. MHA is one of 320 local affiliates of National Mental Health America. The MHA of Wisconsin has 18 employees, three offices statewide with their primary office in Milwaukee, and a budget of more than $1.4 million. The nonprofit organization is dedicated to helping all people live mentally healthier lives. Their mission is to promote mental health, prevent mental disorders, and achieve victory over severe mental illness through advocacy, education, information, and support.

MHA works with local school districts on suicide prevention projects. MHA submitted a proposal on behalf of the State of Wisconsin for federal funding under the Garrett Lee Smith Memorial Youth Suicide Prevention grant for June 1, 2006 through May 31, 2009 of $1.3M. MHA has received a no-cost extension to complete grant activities by December 31, 2009. The MHA works with local communities, the Wisconsin School for the Deaf and other school districts, and a tribe on suicide prevention projects. Technical assistance is provided to the projects through direct guidance, resources, and educational opportunities to school districts, mental health providers, child welfare staff, parents and others about youth suicide and school mental health through conference presentations, publications and a best practices CD which includes a start-up toolkit and protocols to deal with issues surrounding suicide for schools and communities. Technical assistance 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 Suicide Prevention Resource Center. 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 integration of mental health and primary care. MHA has addressed this in a variety of ways: symposia for primary care physicians, mental health professionals and health plan administrators on integrating mental and physical health; special web pages on its site with information pertaining to primary care integration and consultation with individual health systems. Goals include continuing 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. Most recently MHA has brought this focus to Wisconsin's Screening, Brief Intervention, Referral and Treatment project, advising on the integration of depression screening and intervention into this initiative.
MHA is also furthering these goals part of the WINTIP advisory committee and the Maternal and Child Health Advisory Committee.

**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 MH/AODA 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 “Consumer Relations Coordinator.” The current Consumer Coordinator brings widespread personal experience, knowledge of public and private mental health systems, recovery, and leadership experience. The overall position 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.

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

**Consumer Run, Peer Support Services and Family Support Services**
The state holds a strong value regarding peer support and peer provided services. The DMHSAS has allocated MHBG funding to support consumer-run, peer support services and family support and education services. Currently, the Grassroots Empowerment Project (GEP) is under contract with the DMHSAS, as Wisconsin's only statewide mental health consumer-controlled organization. Stable Life, Inc. a second consumer run organization, has a contract to provide grants to develop and support up to 10 consumer run, peer support grantee sites in various areas of Wisconsin. Five funded sites received funding to develop “Recovery Centers” for which the expectations in their contracts are that they provide more defined services for consumer members. Some programs employ paid consumers to provide services. The GEP staff is expected to provide onsite technical assistance, ongoing support to the ten groups and 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. 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.

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

**NAMI Wisconsin Consumer Council (NWCC)**
The NAMI Wisconsin Consumer Council (NWCC) was formed in 2005. The NWCC is a committee of the NAMI Wisconsin Board of Directors and is exclusively comprised of consumers. The NWCC derives its organizational structure from the NAMI National Consumer Council. The NWCC Council holds consumer leadership summits and has an active membership. The NAMI Wisconsin Recovery Project maintains its own website, and writes a recovery-based section in each issue of the “Iris,” which is the bi-monthly newsletter. The Recovery Project operates a recovery-oriented lending library, speaker’s directory, and brings in national advocates for presentations to Wisconsin. NAMI Wisconsin maintains a toll-free information line for family members and consumers, advocacy services, a NAMI Wisconsin website, and outreach programs to underserved populations. NAMI Wisconsin is currently revising and updating its resource, "The Family and Consumer Resource Guide." NAMI Wisconsin provides NAMI national training programs, which include In Our Own Voice and additional programs designed for mental health consumers, programs for family members including Family to Family, and programs for professionals.

**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](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.
Wisconsin

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 2: Mental Health System Data Epidemiology

Directions: An estimate of the incidence and prevalence in the state of serious severe mental illness among adults and serious emotional disturbance among children.

Estimate of Prevalence

Wisconsin Demographics

Wisconsin is the 18th largest populated state in the United States. The population in 2008 was 5,627,967 according to the U.S. Census Bureau’s estimate. Wisconsin has a mixture of heavy and high tech industry, extensive agriculture and, in the forested north, a strong tourist industry. A majority of the state's population is in the south central and southeastern part of the state, extending up the coast of Lake Michigan to Green Bay. It is the 14th largest state in land area with 35.8 million acres and 1.1 million acres of water. The population of 5,627,967 has 4,243,487 or 75.4 percent are over the age of 18 and 731,635 or 13 percent are over 65 years of age. According to the 2000 census, the composition of Wisconsin's population was 88.9 percent Caucasian, 5.7 percent African American, 3.6 percent Hispanic or Latino, 1.7 percent Asian, 0.1 percent Pacific Islander, and 0.9 percent Native American with other races make up the remaining 1.6 percent. Milwaukee County has the largest population in the state. Additionally, Milwaukee County has the greatest concentration of minority groups with the highest percentage of that population being African American.

Definition of Serious Severe Mental Illness for Adults

Wisconsin has used the following definition to identify its adult population with serious severe mental illness. Wisconsin State Statutes define chronic severe mental illness in section 51.01(3g) as:

"Chronic severe mental illness" means a severe mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. "Chronic severe mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or of alcohol or drug dependence.
Department of Health Services Chapter 63 of the Wisconsin Administrative Code defines Community Support Programs for chronically mentally ill persons. According to the admission criteria, chronic severe mental illness includes the diagnoses listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) that are outlined in Table 11.

The criteria also allow for the inclusion of other diagnoses listed in the DSM-IV provided that the client needs consistent and extensive treatment for at least one year, exhibited persistent dangerousness to self or others, is at risk of institutionalization or living in a severely dysfunctional way, and is functionally impaired.

**Table 11:**
DSM-IV Diagnoses Used to Define Chronic Severe mental illness for Admission to CSPs

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>DSM-IV Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic Disorders</td>
<td>295.30,.10,.20,.90,.60,.40,.70,295.40</td>
</tr>
<tr>
<td>Other Psychotic Disorders</td>
<td>297.1, 298.8, 297.3, 293, 298.9</td>
</tr>
<tr>
<td>Mood Disorders, including Bi-Polar I and II</td>
<td>296.2,3,4,5,6,7,8, 300.4</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td></td>
</tr>
</tbody>
</table>

**Prevalence of Serious Severe Mental Illness for Adults in Wisconsin**

Based on the recommendations of the federal Center for Mental Health Services (CMHS), Wisconsin calculates prevalence rates from a 1997 SAMHSA study entitled “A Methodology For Estimating The 12-Month Prevalence Of Serious Mental Illness (SMI).” The definition of SMI used in the study to derive the prevalence rates includes:

1. 12-month prevalence of non-affective psychosis or mania,
2. 12-month DSM-IV mental disorder and either planned or attempted suicide at some time during the last 12 months,
3. an individual with a DSM-IV diagnosis over the last 12 months and lacks any productive role,
4. an individual with a DSM-IV over the last 12 months who has a serious role impairment in their main productive roles, and
5. an individual with a DSM-IV over the last 12 months with serious interpersonal impairment.

Prevalence rates are available by county from the study and are applied to the 2008 population estimates derived by the U.S. Census Bureau in Table 12 below. The adult population in Wisconsin defined as 18 years of age or older is 4,313,555. When the county-estimated prevalence figures are summed, an estimated 232,932 Wisconsin adults have a serious mental illness which is 5.4 percent of the adult population.
Table 12:  
Wisconsin Adult Prevalence Estimates of SMI by County  
(Estimated Percent of Non-Institutionalized Adults with SMI = 5.40 Percent\(^1\))

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>2008 Population Estimate (Age 18+)</th>
<th>Estimated # of Adults with SMI</th>
<th>COUNTY</th>
<th>2008 Population Estimate (Age 18+)</th>
<th>Estimated # of Adults with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>16,831</td>
<td>909</td>
<td>Marathon</td>
<td>99,986</td>
<td>5,399</td>
</tr>
<tr>
<td>Ashland</td>
<td>12,581</td>
<td>679</td>
<td>Marinette</td>
<td>33,846</td>
<td>1,828</td>
</tr>
<tr>
<td>Barron</td>
<td>35,810</td>
<td>1,934</td>
<td>Marquette</td>
<td>12,038</td>
<td>650</td>
</tr>
<tr>
<td>Bayfield</td>
<td>11,994</td>
<td>648</td>
<td>Menominee</td>
<td>2,991</td>
<td>162</td>
</tr>
<tr>
<td>Brown</td>
<td>184,767</td>
<td>9,977</td>
<td>Milwaukee</td>
<td>703,161</td>
<td>37,971</td>
</tr>
<tr>
<td>Buffalo</td>
<td>10,798</td>
<td>583</td>
<td>Monroe</td>
<td>32,242</td>
<td>1,741</td>
</tr>
<tr>
<td>Burnett</td>
<td>13,068</td>
<td>706</td>
<td>Oconto</td>
<td>29,530</td>
<td>1,595</td>
</tr>
<tr>
<td>Calumet</td>
<td>33,073</td>
<td>1,786</td>
<td>Oneida</td>
<td>29,338</td>
<td>1,584</td>
</tr>
<tr>
<td>Chippewa</td>
<td>46,785</td>
<td>2,526</td>
<td>Outagamie</td>
<td>131,711</td>
<td>7,112</td>
</tr>
<tr>
<td>Clark</td>
<td>24,299</td>
<td>1,312</td>
<td>Ozuakee</td>
<td>66,679</td>
<td>3,606</td>
</tr>
<tr>
<td>Columbia</td>
<td>42,783</td>
<td>2,310</td>
<td>Pepin</td>
<td>5,700</td>
<td>308</td>
</tr>
<tr>
<td>Crawford</td>
<td>13,103</td>
<td>708</td>
<td>Pierce</td>
<td>31,619</td>
<td>1,707</td>
</tr>
<tr>
<td>Dane</td>
<td>376,776</td>
<td>20,346</td>
<td>Polk</td>
<td>34,266</td>
<td>1,850</td>
</tr>
<tr>
<td>Dodge</td>
<td>69,395</td>
<td>3,747</td>
<td>Portage</td>
<td>54,383</td>
<td>2,937</td>
</tr>
<tr>
<td>Door</td>
<td>22,688</td>
<td>1,225</td>
<td>Price</td>
<td>11,557</td>
<td>624</td>
</tr>
<tr>
<td>Douglas</td>
<td>34,296</td>
<td>1,852</td>
<td>Racine</td>
<td>149,973</td>
<td>8,099</td>
</tr>
<tr>
<td>Dunn</td>
<td>33,894</td>
<td>1,830</td>
<td>Richland</td>
<td>14,074</td>
<td>760</td>
</tr>
<tr>
<td>Eau Claire</td>
<td>77,125</td>
<td>4,165</td>
<td>Rock</td>
<td>120,885</td>
<td>6,528</td>
</tr>
<tr>
<td>Florence</td>
<td>3,821</td>
<td>206</td>
<td>Rusk</td>
<td>11,254</td>
<td>608</td>
</tr>
<tr>
<td>Fond du Lac</td>
<td>77,185</td>
<td>4,168</td>
<td>Sauk</td>
<td>61,253</td>
<td>3,308</td>
</tr>
<tr>
<td>Forest</td>
<td>7,714</td>
<td>417</td>
<td>Sawyer</td>
<td>45,175</td>
<td>2,439</td>
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<tr>
<td>Grant</td>
<td>39,213</td>
<td>2,118</td>
<td>Shawano</td>
<td>13,438</td>
<td>726</td>
</tr>
<tr>
<td>Green</td>
<td>27,694</td>
<td>1,495</td>
<td>Sheboygan</td>
<td>31,676</td>
<td>1,711</td>
</tr>
<tr>
<td>Green Lake</td>
<td>14,580</td>
<td>787</td>
<td>St. Croix</td>
<td>88,082</td>
<td>4,756</td>
</tr>
<tr>
<td>Iowa</td>
<td>17,945</td>
<td>969</td>
<td>Taylor</td>
<td>14,970</td>
<td>808</td>
</tr>
<tr>
<td>Iron</td>
<td>5,224</td>
<td>282</td>
<td>Trempealeau</td>
<td>21,353</td>
<td>1,153</td>
</tr>
<tr>
<td>Jackson</td>
<td>15,606</td>
<td>843</td>
<td>Vernon</td>
<td>21,804</td>
<td>1,177</td>
</tr>
<tr>
<td>Jefferson</td>
<td>62,524</td>
<td>3,376</td>
<td>Vilas</td>
<td>18,071</td>
<td>976</td>
</tr>
<tr>
<td>Juneau</td>
<td>20,976</td>
<td>1,133</td>
<td>Walworth</td>
<td>78,082</td>
<td>4,216</td>
</tr>
<tr>
<td>Kenosha</td>
<td>122,168</td>
<td>6,597</td>
<td>Washburn</td>
<td>13,329</td>
<td>720</td>
</tr>
<tr>
<td>Kewaunee</td>
<td>15,968</td>
<td>862</td>
<td>Washington</td>
<td>99,117</td>
<td>5,352</td>
</tr>
<tr>
<td>La Crosse</td>
<td>88,366</td>
<td>4,772</td>
<td>Waukesha</td>
<td>293,719</td>
<td>15,861</td>
</tr>
<tr>
<td>Lafayette</td>
<td>12,191</td>
<td>658</td>
<td>Waupaca</td>
<td>40,375</td>
<td>2,180</td>
</tr>
<tr>
<td>Langlade</td>
<td>15,990</td>
<td>863</td>
<td>Waushara</td>
<td>19,823</td>
<td>1,070</td>
</tr>
<tr>
<td>Lincoln</td>
<td>23,039</td>
<td>1,244</td>
<td>Winnebago</td>
<td>126,945</td>
<td>6,855</td>
</tr>
<tr>
<td>Manitowoc</td>
<td>63,207</td>
<td>3,413</td>
<td>Wood</td>
<td>57,543</td>
<td>3,107</td>
</tr>
</tbody>
</table>

State Total 4,313,555 232,932

---

Treated Prevalence

Wisconsin counties are required to report the number of persons who receive mental health services using the HSRS data system. According to the HSRS data, Wisconsin’s public mental health system served 79,740 adults in CY 2008. Based on the estimated prevalence from Table 12 of 232,932 adults with SMI in Wisconsin, the public mental health system served 34 percent of the adults with SMI in Wisconsin.
Wisconsin

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 2: Mental Health System Data Epidemiology

Quantitative Targets

Directions: Quantitative Targets to be achieved in the implementation of the system of care described under Criterion 1.

CRITERION 1

ADULT PLAN QUANTITATIVE TARGETS

2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 1: Decrease the rate of readmission to psychiatric hospitals within 30 days.
(National Outcome Measure)

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

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Decrease psychiatric hospital episodes within 30 days.

Indicator: The percentage of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days.

Measures: Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days. Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010.

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.

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 Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 2: Decrease the rate of readmission to psychiatric hospitals within 180 days.
(National Outcome Measure)

Objective: Decrease the rate of readmission to psychiatric hospitals within 180 days by two percent annually.

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Decrease psychiatric hospital episodes within 180 days.

Indicator: The percentage of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days.

Measure: Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days. Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010.

Sources of Information: HSRS data.

Special Issues and Strategies: 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.

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 Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.
<table>
<thead>
<tr>
<th>Goal 3:</th>
<th>To facilitate the use of evidence-based practices for adults. (National Outcome Measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective:</td>
<td>To facilitate the use of evidence-based practices for adults by funding their implementation and disseminating training resources.</td>
</tr>
<tr>
<td>Population:</td>
<td>Adults with SMI.</td>
</tr>
<tr>
<td>Criterion:</td>
<td>Comprehensive Community-Based Mental Health Service Systems.</td>
</tr>
<tr>
<td>Brief Name:</td>
<td>Evidence-Based Practices Used.</td>
</tr>
<tr>
<td>Indicator:</td>
<td>Number of evidence-based practices used for adults in the state in FFY 2010.</td>
</tr>
<tr>
<td>Measure:</td>
<td>Number of evidence-based practices used for adults in the state in FFY 2010.</td>
</tr>
<tr>
<td>Special Issues and Strategy:</td>
<td>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.</td>
</tr>
<tr>
<td>Significance:</td>
<td>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.</td>
</tr>
</tbody>
</table>
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 4: To facilitate the use of evidence-based practices for adults.
(National Outcome Measure)

Objective: To facilitate the use of evidence-based practices for adults by funding their implementation and disseminating training resources.

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Adults Receiving Evidence-based Practices.

Indicator: Number of adults receiving evidence-based practices in the state in FFY 2010.

Measure: Number of adults receiving evidence-based practices in the state in FFY 2010.

Sources of Information: CSP Monitoring report for ACT reporting. Individual county reports on consumers served with other EBP’s. Other sources to be determined.

Special Issues Strategy: The first task for Wisconsin is collecting reliable statewide data and 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.

The activities described below address Goal 2, Recommendations 2.1 and 2.3; and Goal 5, Recommendation 5.1 and 5.2 of the President's Freedom Commission on Mental Health:

Goal 2--Mental health care is consumer and family driven.
Recommendation 2.1--Develop an individualized plan of care for every adult with a serious severe mental illness and child with a serious emotional disturbance.
Recommendation 2.3--Align relevant Federal programs to improve access and accountability for mental health services.

Goal 5--Excellent mental health care is delivered and research is accelerated.
Recommendation 5.1--Accelerate research to promote recovery and resilience, and ultimately to cure and prevent severe mental illnesses.
Recommendation 5.2--Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
# STATE PLAN PERFORMANCE INDICATOR
## FFY 2010

### Criterion 1

**Goal 5:** Improve client perception of care. (National Outcome Measure)

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

**Population:** Adults with SMI.

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

**Brief Name:** Increase consumer satisfaction.

**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 2010.

**Measure:**
- **Numerator:** the number of adults with a "positive" response about the outcome of their treatment measured by the Outcomes scale in FFY 2010.
- **Denominator:** the total number of adults responding to the survey in FFY 2010.

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

**Special Issues and Strategy:** 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 6: Implement new CCS programs to increase funding for an expanded array of services.

Objective: To implement the CCS benefit in an additional 4 percent of Wisconsin’s counties annually.

Population: Adults and older adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Expand array of services with CCS.

Indicator: Percentage of counties in Wisconsin who implement the new CCS benefit in FFY 2010.

Measure: Numerator: the number of counties who implement the new CCS benefit in FFY 2010.
Denominator: the total number of Wisconsin counties in FFY 2010.

Sources of Information: State data on counties who become certified to provide the CCS benefit.

Special Issues and Strategy: None.

Significance: CCS is becoming a strong component of Wisconsin’s comprehensive service continuum as more counties become certified to provide CCS every year in addition to their CSP. CCS is a Medicaid-funded service which should increase the number of consumers with access to flexible services for recovery. This is an important development in Wisconsin’s service array.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 7: Increase or retain employment for mental health consumers. (National Outcome Measure)

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

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Increase employment.

Indicator: The percentage of adults with SMI in the labor force who are employed in FFY 2010.

Measure: Numerator: Number of adults 18 and older with SMI who are employed in FFY 2010.
Denominator: Number of adults 18 and older with SMI who are employed, unemployed, or not in the labor force in FFY 2010.

Sources of Information: 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.
STATE PLAN PERFORMANCE INDICATOR  
FFY 2010  

Criterion 1  

Goal 8: Decrease criminal justice involvement for mental health consumers.  
(National Outcome Measure)  

Objective: To decrease the percentage of adult mental health consumers who recidivate by four percent annually.  

Population: Adults with SMI.  

Criterion: Comprehensive Community-Based Mental Health Service Systems.  

Brief Name: Decrease criminal justice involvement.  

Indicator: The percentage of adults with SMI with no arrest in FFY 2010 after being arrested in FFY 2009.  

Measure: Numerator: Number of adults 18 years and older with SMI who were arrested again in FFY 2010 after being arrested in FFY 2009.  
Denominator: Number of adults 18 years and older with SMI who were arrested in FFY 2009.  

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

Special Issues and Strategy: 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 2009 or FFY 2010. The indicator focuses on adults arrested in FFY 2009 to see if they were able to avoid being arrested again in FFY 2010.  

Significance: Involvement with the criminal justice system is sometimes associated with severe mental illness. 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 9: Increase social supports/social connectedness.
   (National Outcome Measure)

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

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Increased social supports.

Indicator: The number of adults with SMI who have social supports in their community in FFY 2010.

Measure: Numerator: Number of adults 18 and older with SMI who agree they have social supports to rely on in their community in FFY 2010. 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 2010.

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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 10: Improved level of functioning. (National Outcome Measure)

Objective: To increase the percentage of consumers with improved functioning by two percent annually.

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Improved level of functioning.

Indicator: The percentage of adults with SMI who report improved functioning as a result of their mental health services in FFY 2010.

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 2010. Denominator: Number of adults 18 and older with SMI responding about their general ability to function on the MHSIP satisfaction survey in FFY 2010.

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

Special Issues and Strategy: 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 five-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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 11: To facilitate the use of Integrated Dual Disorder Treatment (IDDT) as an evidence-based practice for adults.

Objective: To facilitate the use of IDDT as an evidence-based practice for adults by funding their implementation and disseminating training resources.

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Adults Receiving IDDT.

Indicator: Number of adults receiving IDDT as an evidence-based practice in the state in FFY 2010.

Measure: Number of adults receiving IDDT as an evidence-based practice in the state in FFY 2010.

Sources of Information: Individual reports from pilot counties funded to implement EBPs.

Special Issues and Strategy: Wisconsin is currently facilitating the implementation of EBPs through the provision of grants to five counties. Three counties are implementing IDDT and are reporting on the number of consumers served. 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 13: To facilitate the use of Supported Employment as an evidence-based practice for adults.

Objective: Using the Supported Employment evidence-based practice in three local programs to serve 100 percent of the expected capacity of 45 adults annually.

Population: Adults with SMI.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Adults Receiving Supported Employment.

Indicator: The percentage of adult consumers receiving Supported Employment services of the expected capacity of 45 in FFY 2010.


Sources of Information: Individual reports from counties funded to implement Supported Employment.

Special Issues and Strategy: The Division of Vocational Rehabilitation (DVR) is using Supported Employment in three local sites. The DVR is focusing on mental health consumers in Community Support Programs which are based on the Assertive Community Treatment model. Program staffing levels indicate a capacity to serve approximately 45 consumers per year.

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.
CRITERION 2

ADULT PLAN QUANTITATIVE TARGETS
2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 2

Goal 1: To increase the number of adults who have access to services in the public mental health system. (National Outcome Measure)

Objective: Increase by one percent the number of adults served through the public mental health system.

Population: Adults with SMI.

Criterion: Mental Health System Data Epidemiology.

Brief Name: Increase access to services.

Indicator: Number of adults 18 and older receiving mental health services in FFY 2010.

Measure: Numerator: Number of adults 18 and older receiving services through the public mental health system in FFY 2010 minus the number of adults 18 and older receiving services through the public mental health system in FFY 2009.
Denominator: Number of adults 18 and older receiving services through the public mental health system in FFY 2009.

Sources of Information: Human Services Reporting System data.

Special Issues and Strategies: The data to monitor Wisconsin's progress on access to care for adults will be taken directly from Basic Data Table 2A, which we are required to report in the annual Implementation Report. The Implementation Report in which Wisconsin reports on this indicator is due to be completed December 1, 2009.

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 in this section.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 2

Goal 2: Increase access to mental health services by expanding the use of the CCS benefit in counties.

Objective: To increase the number of consumers served in CCS programs by 10 percent annually.

Population: Adults with SMI.

Criterion: Mental Health System Data Epidemiology.

Brief Name: Increase access to services.

Indicator: The percentage change in the number of adult consumers served in Wisconsin in CCS programs from FFY 2009 to FFY 2010.

Measure: Numerator: Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2010 minus the number of adults 18 and older receiving CCS services through the public mental health system in FFY 2009.
Denominator: Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2009.

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

Special Issues and Strategy: Although CCS is a Medicaid benefit and thus almost all CCS recipients would be recorded in the state Medicaid data base, all consumers served should also be recorded in the HSRS data base. All CCS recipients are served within the public mental health system and all public mental health service recipients are recorded in the HSRS data.

Significance: CCS began as a Medicaid benefit in 2005 for the provision of psychosocial rehabilitation services. Although not funded through Medicaid previously, CCS is not a new component to the Wisconsin mental health system. However, it’s availability as a Medicaid-reimbursable benefit is expected to increase its use by providers to serve more consumers with a level of need appropriate for CCS. This is an important development in Wisconsin’s service array.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 2

Goal 3: Increase access to, and appropriateness of, mental health services by expanding the use of the MH/AODA Functional Screen. (State Transformation Outcome Measure)

Objective: To increase the use of the MH/AODA Functional Screen in additional counties by five percent.

Population: Adults with Serious Severe mental illness and co-occurring substance abuse issues

Criterion: Comprehensive Community Based Mental Health Systems

Brief Name: Expansion of MH/AODA Functional Screen

Indicator: The percentage of counties using the MH/AODA Functional Screen.

Measure: Numerator: The number of counties using the MH/AODA Functional Screen in FFY 2010. Denominator: The total number of counties in Wisconsin.

Source of Information: MH/AODA Functional Screen data.

Special Issues and Strategy: None.

Significance: The implementation of the MH/AODA 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 2

Goal 4: Increase access to, and appropriateness of, mental health services by expanding the use of the MH/AODA Functional Screen.
(State Transformation Outcome Measure)

Objective: To increase the number of consumers screened with the MH/AODA Functional Screen by five percent annually.

Population: Adults with SMI.

Criterion: Mental Health System Data Epidemiology.

Brief Name: Increase MH/AODA identification.

Indicator: The percentage change in the number of completed MH/AODA Functional Screens from FFY 2009 to FFY 2010.

Measure: Numerator: Number of MH/AODA Functional Screens completed in FFY 2010 minus the number of completed MH/AODA Functional Screens in FFY 2009.
Denominator: Number of completed MH/AODA Functional Screens in FFY 2009.

Sources of Information: MH/AODA Functional Screen data.

Special Issues and Strategy: The MH/AODA 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. Both initial and annual screens are included in the calculations for this indicator.

Significance: Several years ago, the Wisconsin Department of Health Services committed to a web-based system of functional screening for all target groups receiving public funding for services. As part of this web based system, the Department made the decision to focus on functional eligibility for entry into programs and for mental health and co-occurring conditions, to focus on a screen for individuals needing community psycho-social rehabilitation services beyond outpatient treatment. In Wisconsin, there are two statewide psychosocial rehabilitation programs. One is the Community Support Program, (CSP) which is based on the Assertive Community Treatment model, and Comprehensive Community Services (CCS), which is a wide-ranging psychosocial rehabilitation program across the lifespan. Entry to CSP and CCS for adults is via the web–based functional screen for adults. This indicator describes one of Wisconsin’s major initiatives and corresponds directly to the New
Freedom Commission’s Goal 6 to use technology to improve access to care and Goal 4 to screen for co-occurring mental health and substance abuse disorders.
CRITERION 4

ADULT PLAN QUANTITATIVE TARGETS
2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 4

Goal 1: To increase access to mental health services for adults with a SMI in rural areas.

Objective: Increase by two percent the number of rural counties with a CSP.

Population: Rural Adults who have a SMI.

Criterion: Targeted Services to Rural and Homeless Populations.

Brief Name: Access to Services in Rural Areas.

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

Measure: Numerator: The number of rural counties with certified CSPs in FFY 2010.

Denominator: The number of rural counties in FFY 2010.

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

Special Issues and Strategy: There are currently eight counties which do not have a CSP and all but one is rural. Another county will be selected in FFY 2010 for CSP expansion.

Significance: Much of Wisconsin is rural and access to mental health services within these areas remains a significant need and priority.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 4

Goal 2: Increase stability in housing.  (National Outcome Measure)

Objective: Increase the number of adults with SMI who are homeless that receive mental health services by five percent annually.

Population: Adults with SMI.

Criterion: Targeted Services to Rural and Homeless Populations.

Brief Name: Access to services for adults who are homeless.

Indicator: The percentage of adults with SMI who are homeless who receive mental health services in FFY 2010.

Measure: Numerator: The number of adults with SMI who are homeless who receive mental health services in FFY 2010 minus the number of adults with SMI who are homeless who receive mental health services in FFY 2009.

Denominator: The number of adults with SMI who are homeless who receive mental health services in FFY 2009.

Source(s) of Information: The Human Services Reporting System (HSRS).

Special Issues and Strategy: 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 2010 MHBG funds in CY 2010. 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.
CRITERION 5

ADULT PLAN QUANTITATIVE TARGETS
2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 5

Goal 1: Maintain resources to consumer-run programs and services and to family support services.

Objective: Maintain funding for consumer and family programs and services.

Population: Consumers and family members.

Criterion: Management Systems.

Brief Name: Resources for consumer support programs.

Indicator: Percentage change in the amount of funds allocated to family support and consumer-run programs, services and training in FFY 2010.

Measure: Numerator: FFY 2009 funds allocated to consumer-run and family support programs subtracted from FFY 2010 funds allocated to consumer-run and family support programs.
Denominator: FFY 2009 funds allocated to consumer-run and family support programs.

Sources of Information: MHBG funding allocation data.

Special Issues And Strategy: Wisconsin’s goal is to maintain or increase funding levels for consumer and family support services in FFY 2010. 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.
Wisconsin

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

**Criterion 4: Targeted Services to Rural and Homeless, and Older Adults Populations**

**Directions:** Describe State's outreach to and services for individuals who are homeless.

**Outreach to Homeless**

**People Who are Homeless and Have a Serious Severe Mental Illness**

The Division of Mental Health and Substance Abuse Services (DMHSAS) is committed to the inclusion of homeless individuals in the system of services and supports Wisconsin offers to residents with mental health and substance abuse issues.

**Mental Health Block Grant County Reporting**

County mental health and systems are required to report numbers of homeless people with severe mental illness served at the local level on the Human Services Reporting System (HSRS). The Division’s state county contracts require that counties serve the homeless as a priority population. The following data was taken from the HSRS mental health module for 2008. All the individuals listed received mental health services in 2008.

**Received a Mental Health Service during 2008 and Residential Arrangement was Street or Shelter**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Under 21</th>
<th>21-59</th>
<th>60+</th>
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<tr>
<td>Male</td>
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<td>40</td>
</tr>
<tr>
<td>Female</td>
<td>560</td>
<td>31</td>
<td>484</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>1,277</td>
<td>69</td>
<td>1,123</td>
<td>85</td>
</tr>
</tbody>
</table>

One of the more critical components for this population is outreach and access. Typically they do not seek out services and often do not have benefits or the benefits have lapsed due to a number of factors. 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 severe 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.

Waukesha Jail Diversion Program—October 1, 2007 through September 30, 2008

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.

- 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 template.

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
- Emergency response
*Refer to Section "Available Services Adults" for more detail on ADRC's.

Additionally, in Wisconsin, the Community Support Program was adopted as the framework for developing a comprehensive range of services that would allow people with SMI to live successfully outside of institutions. Many individuals who are homeless meet the criteria for the two priority target populations—(a) persons who need ongoing low intensity, comprehensive services, and (b) persons who need ongoing, high intensity, comprehensive services. However, the number of people in need of services far exceeds the capacity of the programs that are supposed to serve them. As a result, many people with SMI receive fragmented and uncoordinated treatment, housing, and support services, if they receive them at all. They may cycle in and out of hospitals, jails, shelters, and life on the street at enormous cost to both themselves and their communities.

To address some of this need, Comprehensive Community Services initiatives are also being implemented across the state. For example, the Administrator of the Division of Mental Health and Substance Abuse Services and the Bureau’s Coordinator of Comprehensive Community Services are serving as a resource to the Milwaukee Division of Behavioral Health and other stakeholders on their Special Needs Housing Action Team. The team has formed to do the following:

- Support Milwaukee Continuum of Care in its efforts to maximize the amount of HUD funding coming to Milwaukee County for housing development projects that serve homeless and special needs populations.
- Assess the local affordable special needs housing infrastructure, identifying the biggest gaps in that infrastructure, define the highest priority need, and develop a vision and roadmap for creating a sufficient supply of safe, decent and affordable housing for Milwaukee County’s most vulnerable residents.
- Develop practical strategies to help housing developers assemble the elements needed for successful special needs housing: sites, financing, and services that support residents.
- Identify and establish strategies to secure the diverse range of fiscal resources that will be necessary for the continued development and support of affordable housing for persons suffering from severe mental illness and/or substance abuse, including non-governmental sources of funding from foundations, corporate donors, etc.

The DMHSAS continues to collaborate with the Division of Health Care Access and Accountability to assure access to services through the SSI Managed Care state wide initiative which offers all primary and acute care services in the state plan to all individuals with SSI or SSI related disability funding. We are helping counties write memorandums of understanding with the Health Maintenance Organizations (HMO) involved, and assisting with access issues for consumers.

The DMHSAS remains committed to seeking opportunities to promote service delivery to the mental health individuals who are homeless with their partners at the county level and other willing providers.

Over the past four decades, the care of people with serious severe mental illness (SMI) has shifted from state and county hospitals to the community. Deinstitutionalization sought to provide treatment for people with severe mental illness in the least restrictive setting. However, the reality that people with serious severe mental illness face in the community is in stark contrast to the
promise of deinstitutionalization. The vast array of services and supports that people with serious severe mental illness need in order to survive in the community has not materialized.

Homelessness is typically more than being without a home. Persons with serious severe mental illnesses who are homeless are often unattached from mainstream society on a number of dimensions including health care, employment, connection with family and friends and the broader community. Many individuals present with co-occurring disorders of severe mental illness and substance abuse, and a history of trauma, which impairs their ability to function. People with SMI and/or co-occurring substance abuse disorders become homeless because they are poor, and mainstream health, mental health, housing, vocational, and social service programs are unwilling or unable to serve them. People with both disorders are at greater risk for homelessness because they tend to have more severe mental health symptoms, to deny both their severe mental illness and their substance abuse problems, to refuse treatment and medication, and to abuse multiple substances. They are subject to ongoing discrimination, stigma, and even violence. The lack of appropriate treatment for co-occurring disorders means that even individuals who are motivated to get help may be unable to find it or have to face long waits for services.

There is also a well-documented relationship between homelessness, severe mental illness, substance abuse and victimization. People who have been abused are more vulnerable to ongoing stresses that may lead to severe mental illness, substance abuse and homelessness. Research shows that as many as 97 percent of women with serious severe mental illness report some form of physical or sexual abuse; over 70 percent of women in treatment for drug or alcohol disorders report being sexually abused as children or adults, and over a third have been victims of violent crime.

Abuse in childhood may leave individuals vulnerable to ongoing abuse in adult relationships. People with SMI and/or co-occurring substance abuse disorders living on the streets or in shelters are frequently victims of criminal activity. Poverty and poor survival skills place them in dangerous situations in which they are vulnerable to attack. Individuals with SMI have fewer skills and resources to overcome the effects of trauma, and are particularly likely to be victimized while homeless, and to suffer more severe consequences of ongoing abuse. These individuals require trauma sensitive services to help them regain psychiatric and residential stability.

In Wisconsin, the Community Support Program was adopted as the framework for developing a comprehensive range of services that would allow people with SMI to live successfully outside of institutions. Many individuals who are homeless meet the criteria for the two priority target populations– (a) persons who need ongoing low intensity, comprehensive services; and (b) persons who need ongoing, high intensity, comprehensive services. However, the number of people in need of services far exceeds the capacity of the programs that are supposed to serve them. As a result, many people with SMI receive fragmented and uncoordinated treatment, housing, and support services, if they receive them at all. They may cycle in and out of hospitals, jails, shelters, and life on the street at enormous cost to both themselves and their communities. A conservative estimate by the National Resource Center on Homelessness and Severe mental illness suggests that there are at least 7,500 adults with serious severe mental illnesses who are homeless in Wisconsin.
Projects for Assistance in Transition from Homelessness

Projects for Assistance in Transition from Homelessness (PATH) funding continues to be administered through The Department of Commerce, Division of Housing and Community Development, Bureau of Supportive Housing. Also continuing is a Memorandum of Understanding between DHS and the Department of Commerce that contains 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 will 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 (5) programs in areas of the state with some of the largest populations of people who have SMI and are homeless. These programs include: 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 of these people.

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 these people not to stay in one place very long often impedes simply having application submitted. Approval of an application is rare.

PATH funds, combined with Mental Health Block Grant funds, ($74,000 for 2008) was 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 have developed SOAR training teams who have attended national training and are qualified to teach service providers to utilize the SOAR model to assist their clients in applying for SSI/SSDI. In 2008, close to 150 people were trained to implement the SOAR model in their communities. These trainings will continue 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 understands 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 these objectives can be accomplished though the development of a SOAR Program Task Force, which will convene for the first time at the upcoming Wisconsin PATH Conference.

PATH funds continued 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 being used to hold a Wisconsin PATH Conference. Over 50 service providers representing five PATH-funded and more than 20 non-PATH-funded agencies will be attending the conference. The keynote speaker for the event is a nationally known speaker who will provide 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 from Homelessness (PATH) to Wisconsin. The PATH funding will again be administered by the Wisconsin Department of Commerce. 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 can assist 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 people who are homeless and mentally ill are just one of the target populations that grantees can serve through TBRA, it seem 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 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.

**Crisis Services for Homeless Individuals**

There are 31 counties that operate certified crisis programs under Wisconsin Administrative Rule DHS 34. Crisis programs provide some of the initial outreach and services to individuals and families who are homeless. The crisis stabilization programs will do initial assessments to determine mental health needs and make referrals to appropriate services.
Wisconsin

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

**Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations**

**Directions:** Describe how community-based services will be provided to individuals in rural areas.

**Community Based Services for Rural Individuals**

**Targeted Services for Rural Populations**

Chapter 51, Wis. Stats., mandates that mental health service needs be identified, budgeted for, and provided at the local level in all 72 counties. Numerical size of the county is not a distinction made within the law. The identified need of the citizen residing in the county is the determinant for service response.

**Definition of a Rural Area**

Wisconsin's definition of a rural area is based on the definition of an urban area. A rural area is a county not classified as a "metropolitan area," as defined by the State and Metropolitan Area Data Book, 5th Edition 1997 – 1998, US Department of Commerce, Economics and Statistics Administration, Bureau of the Census. Using the Census Bureau’s definition of a metropolitan area containing a place with a population of 50,000 or greater, Wisconsin has 14 urban counties (19 percent) and 58 rural counties (81 percent). The urban counties identified using this definition include Milwaukee, Dane, Brown, Outagamie, Rock, Eau Claire, Fond du Lac, Kenosha, Racine, La Crosse, Waukesha, Winnebago, Sheboygan, and Marathon. All other counties are considered rural for the purpose of discussing targeted mental health services in this section.

Both rural and inner city areas of Wisconsin encounter access issues due to the uneven distribution of the health care workforce and a fragile health care infrastructure. A significant number of communities are federally designated as health professional shortage areas. These include parts of larger cities, large numbers of rural areas throughout the state, most tribal populations, and low-income populations. For example, considerable variation exists in levels and quality of emergency medical services in rural Wisconsin (National Conference of State Legislators, August 2000). Some very rural counties in Wisconsin have severe shortages of primary care, dental, and mental health providers. There is a shortage of providers who will supply health care to low-income and MA populations.

**Challenges to the Provision of Rural Mental Health Services**

Wisconsin's community mental health system has resource limitations. Workforce shortages stem to a great degree from low population densities in the extensive rural parts of the state (see Section II for a description of Wisconsin's geography). In rural, less densely populated counties,
county-based mental health programs often lack the immediate availability and access to psychiatric and psychological services. Transportation is often a barrier for consumers and their families. A lack of public transportation especially limits their ability to attend peer and family support programs. These limitations result in the lack of choice of mental health and substance abuse providers. Specific areas of need include mental health evaluation, assessment, medication management, treatment, and review.

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 without the psychiatrist even seeing a consumer. To meet this challenge, Wisconsin is moving forward with allowing MA-reimbursement for mental health services provided through tele-health technology.

**Addressing Workforce Development**

Wisconsin recognizes the need to improve recruitment, retention and training of mental health professionals along a spectrum of education and experience regarding rural health care. It is critical to grow the local workforce, meaning to educate, train, recruit and retain mental health professionals in order to meet and sustain the demand for competent rural health care.

**Psychiatric Shortage Problems in Wisconsin**

Wisconsin, like many states, is experiencing an ongoing shortage of highly trained mental health professionals. This shortage is further exacerbated by mal-distribution, with rural counties unable to attract critically needed mental health professionals despite salaries competitive with urban areas. This shortage results in long wait lists, excessive and inappropriate use of hospitalization and emergency services, stress and burnout in the existing workforce, ineffective treatment interventions as primary care generalists attempt to treat complex mental health problems, excessive disability and suffering.

**Tele-Mental Health Initiative**

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.

The richness of expertise and experience at the University of Wisconsin-Madison (UW-Madison) stands in sharp contrast to the dearth of mental health resources in rural Wisconsin. Indeed, this might be viewed as an extreme example of resource mal-distribution. The overarching objective of the initiative is to bring rich resources of UW-Madison to rural Wisconsin via audio and video communication technologies.

A three-pronged approach will be used: (a) a tele-health clinic 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 enhance 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 staffed by a highly trained and experienced medical/mental health librarian.
This project will build upon 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).

The following are specific objectives by grant year:

- **Year 1.** 500 hours of direct tele-mental health services to rural counties, four evidence-based distance education programs, MHERC contact with all 72 counties;
- **Year 2.** As in Year 1, plus an additional 1,000 hours of direct tele-mental health services utilizing supervised trainees;
- **Year 3.** As in Years 1 and 2, plus (a) expansion to subspecialties, including geriatric psychiatry, substance abuse, and child psychiatry, and (b) work on sustainability issues, including further grants and fee-for-service operations.

The goal of the initiative is to reduce the disability and suffering that result from the inadequate treatment of severe mental illness. More specifically, this project is designed to remediate inadequate treatment that occurs in rural Wisconsin as a result of mental health as a result of mental health specialist workforce shortages. The project will target this inadequate treatment via three distinct approaches:

- **Bringing well-qualified specialists to rural communities.** The project will provide specialists to rural communities using real-time, interactive audio and visual communications technologies.
- **Enhancing the exiting workforce.** The project will deliver quarterly professional development workshops focused on new developments in evidence-based practice. These workshops will be delivered via the above communications technologies.
- **Responding to and assisting the existing workforce.** The project will provide meaningful access to the published scientific literature on mental disorders and their treatment through the services of the Mental Health and Education Resource Center (MHERC).

**Background**

The Division of Mental Health and Substance Abuse (DMHSAS) in partnership with counties, provider, consumers and families are moving towards a more recovery based system for children and adults. The guiding principles of this system include but are not limited to: recovery, hope, outcome based, strength based, consumer/family involvement and empowerment. Examples of programs that are being implemented that focus on these values and principles include Comprehensive Community Services (CCS), Coordinated Service Teams (CST), Integrated Service Programs ISP) and Crisis Intervention Services. But these implementation efforts are somewhat jeopardized by the lack of psychiatric expertise in recovery based systems of care and availability of time to provide direct services.

This is especially true in the area of specialty psychiatrists – child and geriatric. The issue of lack of child psychiatry has been brought to the attention of the Secretary of the Department of Health
Services by the Child Come First Advisory Committee, the CST Advisory Committee and a group of concerned provider, consumers and other interested parties in Northern Wisconsin.

The goals of this initiative are as follows:

1. Educate stakeholders and policy makers on psychiatric shortages in Wisconsin and nationally.

2. Share information on what is being done in other states to address psychiatric shortages.

3. Identify all issues that prevent the hiring of skilled psychiatrist in all areas of Wisconsin.

4. Identify ways to recruit psychiatrist with skills necessary to serve all residents in the state or alternatives methods of assuring that residents with mental health needs have access to quality medical professionals that can meet their needs and wants.

5. Identify individuals and agencies/organizations in the state and elsewhere that DMHSAS should partner with to address these issues.

6. Develop prototype tele-psychiatry services focused on filling critical gaps in public mental health programs.

Outcomes

1. DMHSAS will have a list of individuals and agencies/organizations they can begin to work with to resolve issues around psychiatric shortages.

2. Issues will be identified with an action plan to address problems in the short term and long range to ensure all Wisconsin residents have access to psychiatric care that meets their needs and wants.

Rural Mental Health Services

Tele-health is defined as the use of telecommunication equipment to link mental health and/or substance abuse providers and consumers in different locations. The use of tele-health technology to improve access to mental health services for individuals in rural areas of the state is in accordance with Goal 6 of the NFC, which envisions the use of technology to increase access to services. Tele-health will allow the county to more easily attract a qualified psychiatrist and pay only for the time the person is actually seeing consumers. In addition, if the consumer is in need of hospitalization, the psychiatrist may be more available, through tele-health consultation, to the admitting hospital, as well as to the other treatment professionals, family members, and natural supports.

Tele-health will also enhance the ability of small, remote, rural counties to access specialty services such as child and geriatric psychiatry. This technology should assist in better diagnostic services, medication determinations, and more successful treatment planning for those individuals most in need. Tele-health services can be provided to consumers involved in any certified mental health and/or substance abuse program, such as outpatient services, crisis services, community support services, day treatment programs, and inpatient services. All staff employed by these programs may provide services via tele-health, provided they have received the necessary training and meet program certification standards. The state Medicaid program will reimburse for MA-
covered services delivered via tele-health in the same way it reimburses for face-to-face contacts provided that certain requirements are met.

Another opportunity for rural providers is the Wisconsin Public Psychiatry Project, which has been operating a bi-weekly teleconference since June of 1995. The project is a collaborative effort between the Bureau 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.

University of Wisconsin Department of Psychiatry staff also has provided clinical Mental Health information and background to Department of Health and Family Services pharmacy committees, Comprehensive Community Services programs, and the Center for Best Practice Development initiatives.
Wisconsin

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 4: Targeted Services to Older Adult Populations

Directions: Describe how community-based services will be provided to older adults.

Services for Individuals who are Older and have Severe Mental Illness

Serving Older Adults with Severe Mental Illness

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 done by staff at DMHSAS. An important component of the DMHSAS planning work is the development of the Wisconsin Gero-psychiatry Initiative (WGPI). The WGPI began as a collaborative of community stakeholders interested in making gero-psychiatric expertise available to providers 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 gero-psychiatrists 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 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 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 severe 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 has set aside money for continued outreach and training in the 2010 plan, and will team 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 need treatment but have never been diagnosed or treated for their severe mental illness because of stigma and self isolation.

Additional Efforts to Address Older Adults

The Division’s efforts in providing services to older adults is multi-faceted. The single largest source of funding in the community for Wisconsin older adults is the new long term care managed care program, Family Care. In order to access these services, Wisconsin older adults need to have physical conditions that need nursing management, or functional deficits that require assistance to perform basic activities of daily living. Approximately 55 percent of people enrolled in this long term care program have mental health diagnoses. The Division has been working on several levels with the Family Care program. The Division has provided several trainings and technical assistance events to the Aging and Disability Resource Centers, to allow them to
perform intake and referral to people with severe mental illness seeking services. The Division has provided training at the MCO level for nurses and social workers in person centered planning for people with physical and mental health issues, has provided systems level assistance to the Division of Long Term Care staff on program development for specialized programs for people with mental health and substance abuse issues, and most recently has taken the lead in writing a grant to SAMHSA to improve services to older adults in conjunction with primary care physicians. One part-time person at the division level is dedicated to providing technical assistance to collaborating agencies that provide services to older adults with mental health issues. At the Division level, the key staff from Family Care and the key community care program staff from DMHSAS meet to identify program and service delivery issues and engage in collaboration efforts to improve service delivery within the Departments contracted managed care organizations.

**Adult Disability Resource Centers**

Wisconsin is investing 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 severe mental illness), or their families. The Division of Mental Health and Substance Abuse Services is providing 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.

As of January 2009, there were 28 operational ADRCs serving 40 counties. The ADRC of Southwest Wisconsin-North expanded to serve Crawford County. This gives 67.2 percent of Wisconsinites over age 18 access to an ADRC. DHS has received and reviewed the application from the multi-county and multi-tribal collaboration between Bayfield, Iron, Ashland, Sawyer and Price counties and the Bad River, Lac Courte Oreilles and Red Cliff tribes. The Department is working with current applicants including the multi-county collaboration between Barron, Washburn and Rusk Counties, Pepin, Buffalo and Clark Counties, Douglas County and the multi-county and tribal collaboration between Polk and Burnett Counties and the St. Croix Tribe. Discussion also continues with Milwaukee County to establish the Disability Resource Center.

**Tele-health Services**

Tele-health is defined as the use of telecommunication equipment to link mental health and/or substance abuse providers and consumers in different locations. The use of tele-health technology to improve access to mental health services for individuals in rural areas of the state is in accordance with Goal 6 of the NFC, which envisions the use of technology to increase access to services. Tele-health will allow the county to more easily attract a qualified psychiatrist and pay only for the time the person is actually seeing consumers. In addition, if the consumer is in need of hospitalization, the psychiatrist may be more available, through tele-health consultation, to the admitting hospital, as well as to the other treatment professionals, family members, and natural supports.

Tele-health will also enhance the ability of small, remote, rural counties to access specialty services such as child and geriatric psychiatry. This technology should assist in better diagnostic services, medication determinations, and more successful treatment planning for those individuals most in need. Tele-health services can be provided to consumers involved in any certified mental health and/or substance abuse program, such as outpatient services, crisis services, community support services, day treatment programs, and inpatient services. All staff employed by these programs may provide services via tele-health, provided they have received the necessary training.
and meet program certification standards. The state Medicaid program will reimburse for MA-covered services delivered via tele-health in the same way it reimburses for face-to-face contacts provided that certain requirements are met.

Another opportunity for rural providers is the Wisconsin Public Psychiatry Project, which has been operating a bi-weekly teleconference since June of 1995. The project is a collaborative effort between the Bureau 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.

University of Wisconsin Department of Psychiatry staff also has provided clinical Mental Health information and background to Department of Health and Family Services pharmacy committees, Comprehensive Community Services programs, and the Center for Best Practice Development initiatives.
Wisconsin

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

    Criterion 5: Management Systems

    Directions: Describes financial resources, staffing and training for mental health services providers necessary for the plan.

Resources for Providers

The DMHSAS is the designated mental health authority. The DMHSAS is responsible for funding, setting policy, and establishing program standards for public mental health services for adults with SMI and children with SED. Although there are many collaborators within and outside of state government that assist in the implementation of Wisconsin’s State Mental Health Plan, the DMHSAS has primary responsibility for development and implementation.

Financial Resources, Staffing, and Training

Organization of the State Mental Health Authority

The Division of Mental Health and Substance Abuse Services (DMHSAS) is the designated State Mental Health Authority that directs public mental health services in Wisconsin. The Division is comprised of the Division Administrator, John Easterday, the Deputy Administrator, an office assistant, three program units, and four direct care facilities. The Bureau of Prevention, Treatment, and Recovery (BPTR) is one of the three program units and is responsible for activities related to implementation of the MHBG. The BPTR currently consists of three Sections and 33.9 FTE’s including the Director and the Director’s Program Assistant.

The Bureau of Prevention Treatment and Recovery (BPTR)

The Mental Health Services and Contracts Section is responsible for monitoring the programmatic and administrative guidelines for the provision of mental health outpatient services throughout the state. The section will plan and monitor the implementation of the MHBG including the creation of the federally-required annual Mental Health Plan and Implementation Reports. Staffing for the federally-required Wisconsin Council on Mental Health are also provided by this section. Some integrated MH/SA functions are also the responsibility of the Mental Health Services and Contracts Section. The section will be responsible for mental health and substance abuse programming for the deaf and hard of hearing and the elderly populations and Pre-Admission Screening and Resident Reviews (PASRR). The Mental Health Services and Contracts Section monitors CSPs for adults with severe and persistent mental illness reside as well as programs that target housing and staff coordinate with the Department of Commerce on homeless issues. Finally, all evaluation and contact functions for mental health and substance abuse will reside in this section including the management of the Human Services Reporting System (HSRS), Data Infrastructure Grant (DIG) projects, evaluation design, and data analysis.
The Substance Abuse Services Section provides a focus for services and programs designed primarily for substance abuse consumers. Thus, substance abuse and prevention programs have been consolidated within this section from across the bureau and include oversight of the substance abuse administrative rules, Access to Recovery, methadone programs, the Intoxicated Driver Program (IDP), the injection drug use program, and HIV prevention. The Substance Abuse Treatment and Prevention Block Grant (SATPBG) will be administered from the Substance Abuse Services Section. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) will be created and monitored and staff will provide general oversight of the implementation of the plan. Staffing for the State Council on Alcohol and Other Drug Abuse (SCAODA) will also be provided from this section. Responsibility for substance abuse prevention programming will also reside in this Section.

The Integrated Systems Development Section is responsible for mental health and substance abuse programs and services at both the systems-level and client-level. The section has two units. The Children, Youth, and Families Unit has a Unit Supervisor that directly supervises the unit staff and reports to the Section Chief. The Section Chief directly supervises the Systems Redesign Unit and has overall responsibility for both units. The programs and services in this section either have an integrated MH/SA focus and will strengthen new integrated MH/SA approach.

The Children, Youth, and Families Unit addresses the special needs of children and families who have substance abuse and/or severe mental illness. One of the primary functions of the Children, Youth, and Families Unit is to address the goals of the Governor’s KidsFirst Initiative. All children’s mental health and substance abuse programs and services are consolidated in this unit. Staff with mental health and substance abuse expertise work together to strengthen existing integrated MH/SA approaches and implement new integrated approaches where needed. Staff provide contract monitoring, technical assistance, training, and programmatic guidance to the Integrated Service Projects, Coordinated Service Teams, and hospital diversion programs targeted for children with SED who may also have substance abuse disorders. The unit is responsible for Child Welfare Initiatives, prevention and early intervention programming, and programs to benefit infants such as the Infant Mental Health Initiative. Unit staff will also implement and monitor the new CCS benefit, providing clinical consultation services for consumers with substance abuse and/or severe mental illness, and monitoring child and family advocacy activities.

The Systems Redesign Unit is responsible for the implementation and monitoring of systems-level initiatives for adult mental health and substance abuse service systems. Most initiatives in this unit will focus on systems development and training for local administrators and providers on substance abuse and mental health treatment. Unit staff will continue to implement and monitor the MH/SA Transformation Initiative with a focus on integrated MH/SA screening and treatment, managed care, quality improvement, and the implementation of Recovery principles. Monitoring the implementation and development of Recovery-based outcomes is conducted through contracts and support to the Recovery Implementation Task Force. Unit staff are responsible for preparing counties for human service system disaster response and preparedness. Unit staff are also responsible for continuing to work with the Department of Corrections on programming treatment alternatives to incarceration.
State Mental Health Institutes

Mendota Mental Health Institute, a psychiatric hospital operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services, specializes in serving patients with complex psychiatric conditions, often combined with certain problem behaviors. Mendota provides a secure setting to meet the legal and behavioral needs of our patients. Mendota also operates outpatient treatment services for individuals in the community.

Winnebago Mental Health Institute is a psychiatric hospital owned and operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. Winnebago specializes in serving children, adolescents and adults with complex psychiatric conditions that are often combined with challenging behaviors. Winnebago provides a secure setting to meet the legal, behavioral, treatment and recovery needs of patients.

Secure Treatment Facilities

The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs. A youth’s motivation for positive change is also part of that assessment. Parents or guardians receive program and treatment review reports during a youth’s stay on MJTC.

Sand Ridge Secure Treatment Center offers a range of treatment programs for its patients designed to meet the specific needs of sexually violent persons. The inpatient treatment program consists of several phases and components with a multi-disciplinary approach. It is based on a psycho-social rehab model with an emphasis on cognitive-behavioral and relapse prevention techniques. The length of time in treatment is dependent upon successful program completion as evidenced by the patient's consistent demonstration of mastery of self-management skills.

The Wisconsin Resource Center (WRC) is administered by the Wisconsin Department of Health Services in partnership with the Wisconsin Department of Corrections. WRC is a specialized mental health facility established as a prison under s. 46.056, Wisconsin Statutes. WRC is also identified as a treatment facility for the placement of Sexually Violent Persons (SVPs) detained or admitted pursuant to Chapter 980, Wisconsin Statutes. The facility operates as a secure treatment center and is managed by the Division of Mental Health and Substance Abuse Services. The budgeted capacity of WRC is 404: 344 male inmates transferred from Wisconsin Department of Corrections (DOC) Division of Adult Institution prisons for mental health care and 120 men detained or committed under the SVP program pursuant to Chapter 980 of the Wisconsin Statutes.

Technical Assistance

In addition to DMHSAS staff, the DMHSAS also relies on technical assistance the University of Wisconsin and other agencies provide. Mental Health Block Grant monies are used to fund an expert peer consultant and training for the development of CST initiatives for children. The DMHSAS also funds technical assistance to developing CCS programs to provide leadership on promoting positive behavior supports and to develop trauma sensitive and specific services.

One major area of training offered to mental health service providers every year is on the principles and implementation of Recovery. The DMHSAS partners with the UW-Madison
School of Medicine and Public Health to provide Recovery technical assistance and will continue to work with a Recovery Implementation Task Force to develop Recovery training curriculums for providers. One type of training to be offered is Recovery Awareness training which is the first step in orienting providers to the principles of Recovery. Practitioner Competency Training sessions will also be offered by the Recovery Coordinator to provide more in-depth training on implementing Recovery principles into providers’ work. A third type of training, called Guided Reflections, will be offered to organizations as a whole on Recovery principles including providers, administrators, and case managers.

A fourth and final training on Recovery for providers will be a recovery-oriented boundaries and ethics training for social workers. Disability Rights Wisconsin (DRW) develops and provides some of these Recovery trainings.

**ISP/CST Support**

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 2007. Over 60 people attended each meeting, including staff from all CSTs and ISPs, several private agencies, parents and others.

In 2007, each of the five regions with ISP/CST projects in the state began sponsoring two regional meetings per years. These meetings again occurred in 2008. These meetings are well attended by county and private representatives of the local projects. Approximately 25 people attend five meetings, two times per year. State staff team with Area Administration staff and wraparound consultants to prepare for and lead these local meetings. These smaller meetings addressed issues raised by the regional sites in a more directed and focused approach.

Funding was also allocated to support six locally/regionally tailored trainings and consultation. A variety of topics were addressed in county-specific and regional training sessions held in several counties across Wisconsin. Topics included: System Change, Team-Building & Service Coordination, Role of the Coordinating Committee, Crisis Intervention and Crisis planning, collaboration between law enforcement and human services, violence risk assessment in schools. Three counties, Door, Fond du Lac, and Washington, were provided with ongoing technical assistance to further develop their Wraparound process.

**Tele-Health**

Tele-health will also enhance the ability of small, remote, rural counties to access specialty services such as child and geriatric psychiatry. This technology should assist in better diagnostic services, medication determinations, and more successful treatment planning for those individuals most in need. Tele-health services can be provided to consumers involved in any certified mental health and/or substance abuse program, such as outpatient services, crisis services, community support services, day treatment programs, and inpatient services. All staff employed by these programs may provide services via tele-health, provided they have received the necessary training and meet program certification standards. The state Medicaid program will reimburse for MA-covered services delivered via tele-health in the same way it reimburses for face-to-face contacts provided that certain requirements are met.
Psychiatry Teleconferences

Another opportunity for rural providers is the Wisconsin Public Psychiatry Project, which has been operating a bi-weekly teleconference since June of 1995. The project is a collaborative effort between the Bureau 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.

![Wisconsin Public Psychiatry Network Teleconference Series](image)

The 2008 conference, “Recovery: Promoting Dreams through Evidence-Based Practice” was held in Wisconsin Dells. Twenty-four workshops and three keynote presentations were offered to promote Recovery and Evidence-Based Practice.
Financial Management: Fiscal Context of Wisconsin Community Mental Health Services

Financial management of public mental health services occurs within the DHS and is overseen by the Division of Enterprise Services (DES) and the Office of Program Initiatives and Budget (OPIB). Within DES are various financial management functions, including accounting, purchasing, and information systems. The Office of Program Initiatives and Budget is responsible for budgeting. DMHSAS negotiates and monitors contracts with the counties and with nonprofit organizations/vendors.

Contracts and Grants Management

Data management within the DES utilizes three stand-alone financial reporting systems with interface capabilities: Wisconsin State Management & Accounting Tool, which is the statewide accounting system; Fiscal Management System, which was developed for the DHS; and the Community Aids Reporting System (CARS). The DMT has reporting requirements; and CARS is used to encumber and process payments to the service providers. The three systems have interface capabilities.

Contracts with the counties and nonprofit organizations/vendors are issued annually. General community aids funding is distributed to counties based on formula funding. Factors include population, per-capita income, and the rural/urban nature of the county. Other funds are contracted to counties and private, non-profit vendors for targeted purposes. The Block Grant funds are specifically identified in the contracts for the given services to be provided. Each contract is assigned a contract monitor who establishes the work plan, monitors the contract work plan, and provides assistance to contractors in meeting their contract goals. Contractors are responsible for submitting six-month or annual reports on their progress. A system of peer reviews and site visits for a limited number of contracts annually is also part of contract monitoring plans.

Fiscal Oversight, Monitoring, and Audits

Service providers receive a three-month advance at the start of the contract period. They are required to submit expenditure reports (CARS 600 Report) on a monthly basis. These reports are submitted in hard copy format. Client service data is submitted quarterly. Most counties submit the data with monthly online transmittal. Financial data associated with the service data is submitted semi-annually. This provides the basis for unit costing analysis. The DMHSAS staff monitors quarterly and semi-annual reports, which provide the basis for identifying and addressing given issues and outcome attainment. Vendors are required to undergo an annual audit from an auditor of their choosing and the results are submitted to DES. The DMHSAS contract monitors work with DES and the contractor when there are audit issues to resolve.

Revenues and Expenditures for Mental Health

Medicaid is the largest source of funding for mental health programming. The state GPR funding, along with county tax levy dollars, grant funds (MHBG and PATH) represents 47 percent of the total funding. The state provides funding for a community-based service system. The services for which counties are required to pay the non-federal share include: outpatient mental health for adults in the home or community; crisis intervention; Comprehensive Community Services (CCS); Community Support Programs (CSP); Targeted Case Management; and inpatient hospitalization in the state mental health institutes for individuals under the age of
22 and 65 or older. Many counties in the state allocate county levy tax dollars over the required non-federal share. The state Medicaid non-federal share is approximately 40 percent. Other state and federal Medicaid funds represent amounts not subject to the 60/40 sharing. This may include adjustments/savings from prior year activities and previously allocated inpatient dollars that have been converted to community services due to downsizing the number of institutional beds.

Most importantly, however, is the counties’ contribution to the Wisconsin’s mental health system. Wisconsin has a strong county-based system and the majority of the financial burden of the mental health system falls on counties. In CY 2007, counties contributed a reported $204,551,378 for mental health services. In addition to the Mental Health Block Grant funding, Wisconsin receives other federal funding to support Wisconsin’s mental health service system. The PATH grant of $691,000 to support mental health services for individuals who are homeless in four of Wisconsin’s largest urban areas (responsibility for the PATH program were moved to the Department of Commerce in SFY 2006). An additional $74,000 in state funds were contributed to the four PATH programs which are operated out of the Department of Commerce, Bureau of Supportive Housing. Another $142,200 from a CMHS Data Infrastructure Grant will be used to support the DMHSAS’ capacity for data collection and reporting for the MHBG and other programmatic needs. Wait lists were reduced for CSPs by providing $1,000,000 of state funds for 21 counties. $1,000,000 in GPR is utilized for hospital diversion. Another $1,270,000 of Medicaid funds were used for PASRR Level II screening activities throughout the state. Additionally, $8.8 in GPR is available for IMD relocation and funding for community services.
Wisconsin

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 5: Management Systems

Directions: Provides for training of providers of emergency health services regarding mental health.

Emergency Service Provider Training

Wisconsin’s Emergency and Crisis System

Wisconsin defines crisis intervention as a systematic and organized set of mental health emergency/crisis services and supports provided in the community to individuals and families experiencing heightened emotional distress and/or behavioral disorder. The goal of crisis intervention is to provide alternative and diversionary options to reduce the need for hospitalization and to enhance the community’s crisis response. County crisis programs are certified under Wisconsin Administrative Code DHS 34. Crisis intervention services are dependent upon strong inter-agency coordination and joint training between multiple agencies, i.e., departments of human services, law enforcement, CSP, schools, hospitals, emergency room staff, and private providers. The standards for training are set forth in DHS 34. Crisis program staff training records are maintained locally and are reviewed by the state DHS/Division of Quality Assurance when certifying and re-certifying crisis programs. Currently almost all counties are certified for basic emergency crisis services, and 46 counties are certified under DHS 34 Subchapter III standards for emergency service programs. These programs are eligible for MA or third-party reimbursement.

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 used for the development and/or enhancement of 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 DHS 34 Subchapter III.

There are six county Human Service Departments that function as fiscal agents for their multi-county grant: Shawano-Northeast Region; Washburn-Western Region; Marathon-North Central Region; Washington-Eastern Region; Milwaukee-South Eastern Region; and Ashland-North Western Region. The population served is children and adults in need of emergency mental health services. The objectives of the program include:

- Reduce "unnecessary" admissions to hospitals.
- Reduce length of stays at hospitals.
- Divert children and adults to non-hospital community-based options.

Each regional grant has a coordinating committee that includes stakeholders pertinent to the goals of the initiative. Training law enforcement and mental health workers to work together has improved outcomes.*

*For details on outcomes for the Regional Crisis Response System Initiative, see Children's Section: "Emergency Service Provider Training."

Crisis Intervention Conference

The 12th Annual Crisis Intervention Conference occurred 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. 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 DHS 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 DHS 34.

Topics presented in Keynote Addresses for the conference included:
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?
- 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
Wisconsin

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
Criterion 5
Grant Expenditure Manner
Criterion 5: Management Systems

Directions: Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

Expenditure Plan for Block Grant Funds for FFY 2010—DRAFT

The Mental Health Block Grant application for FFY 2010 is due to Center for Mental Health Services (CMHS) on September 1, 2009. Although the federal 2010 Budget has not yet been passed by Congress, CMHS has instructed the Division of Mental Health and Substance Abuse Services to assume the same level of funding in FFY 2010, as Wisconsin received in FFY 2009, $7,349,062.

Proposed FFY 2010 MHBG Budget

1) County Formula Allocation (Statutory Cap of $2,513,400) - $2,513,400
This allocation is designated to county mental health agencies to fund programs for persons with serious mental illness. The DHS determines each county agency's MHBG allocation using its standard Community Aids formula. This formula considers each county agency's Medicaid caseload, per capita income, and urban/rural designation. Each agency will use the funds for one or more of the following eight priority areas:

- Certified CSP and/or CCS program development and service delivery
- Supported housing program development and service delivery
- Initiatives to divert persons from jails to mental health services
- Development and expansion of mobile crisis intervention programs
- Consumer peer support and self-help activities
- Coordinated, comprehensive services for children with SED
- Development of strategies and services for persons with co-occurring MH/SA disorders
- Mental health outcome data system improvement

2) Children’s Initiatives - ISP and CST (ISP Capped by Statute at $1,306,700, but not CST) - $1,826,500
The ISP initiative is designed to develop coordinated systems of care for children and adolescents with SED and their families requiring support from multiple community-based agencies. State awards give the county projects the capacity to provide the flexibility needed by both children/adolescents and their families. The CST initiative places an even heavier emphasis on collaboration across child-serving systems. The focus is on creating a “systems change” plan for the county or tribe to establish strength-based systems of care that supports children and adolescents and their families who require substance abuse, mental health, juvenile justice, and/or child welfare services.

3) Family/Consumer Self-Help & Peer-to-Peer Support (By Statute, must allocate no less than $874,000) - $991,629
Wisconsin funds a variety of consumer self-help and peer support programs including programs that work with adult consumers, child consumers, and families of consumers.
4) Transformation Activities (No Statute) - $886,033
Per federal focus, Wisconsin will continue to use a portion of the block grant to promote system transformation. Activities include working with State partners, counties, tribes, consumers and advocacy groups to focus on transformation of the county and tribal service systems through start-up grants for CCS/CSP programs and to increase use of evidence-based practices such as Supported Employment. Workforce Development grants will promote solutions for workforce shortages for psychiatric services for children and elders. Workforce Technical Assistance will focus on reducing use of seclusion and restraint and the related need to promote trauma informed care. Tribal State Collaborative funding supports a grant that provides technical assistance and strategic planning support to all tribes to improve each systems delivery of integrated treatment for co-occurring mental health and substance use disorders.

**Detailed Budget Breakout**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>County QI-Continuity of Care</td>
<td>$69,702</td>
</tr>
<tr>
<td>CCS Development/Start-Up</td>
<td>$100,000</td>
</tr>
<tr>
<td>CCS Technical Assistance</td>
<td>$40,240</td>
</tr>
<tr>
<td>Child Welfare Screening</td>
<td>$60,000</td>
</tr>
<tr>
<td>Homeless Access &amp; Outreach to Benefits</td>
<td>$74,000</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>$98,000</td>
</tr>
<tr>
<td>Tribal Best Practices in Co-Occurring Disorder</td>
<td>$100,000</td>
</tr>
<tr>
<td>Workforce Dev. &amp; Psych Consultation</td>
<td>$205,164</td>
</tr>
<tr>
<td>Provider TA to Reduce Seclusion &amp; Restraint/Promote EBPs</td>
<td>$52,927</td>
</tr>
<tr>
<td>Promote Trauma Informed System</td>
<td>$86,000</td>
</tr>
</tbody>
</table>

5) Systems Change (By Statute, at least 10% must be for children) - $222,000
The Systems Change funds will focus heavily on implementing systems change in the areas of improving the current system’s focus on recovery, as well as providing resources for prevention and early intervention and consumer reimbursement as outlined in statutory intent.

**Detailed Budget Breakout**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/Family Stipends for Participation</td>
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</tr>
<tr>
<td>Recovery Coordinator</td>
<td>$82,000</td>
</tr>
<tr>
<td>Prevention/Early Intervention</td>
<td>$95,000</td>
</tr>
<tr>
<td>Youth Suicide Prevention</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

6) Training (Statutory Cap of $182,000) - $177,000
Training funds will be contracted to improve provider knowledge and skills in mental health standards, best practice and emergency crisis services for statewide system delivery for consumers of all ages. These funds support the DMHSAS conferences, training for children’s services, statewide teleconferences on clinical topics, and training for schools on promoting positive behavior supports.

**Detailed Budget Breakout**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Teleconferences</td>
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<tr>
<td>Annual Conference</td>
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</tr>
<tr>
<td>Geriatric Psychiatry Training</td>
<td>$5,000</td>
</tr>
<tr>
<td>Children's Program &amp; Crisis Intervention Training</td>
<td>$32,000</td>
</tr>
</tbody>
</table>
Training for Schools - Positive Behavior Supports $22,958  
Elderly Initiative $20,000  

7) Wisconsin Protection and Advocacy (Statutory Cap of $75,000) - $75,000  
Disability Rights Wisconsin is the designated agency within the state to provide protection and advocacy for persons with mental illness.  

8) State Operation Costs - $657,500  
These funds cover the costs of the staffing for the BPTR, Mental Health Council expenses, accounting, mental health HSRS data expenses, National Outcome Measures reporting and indirect costs of administering the grant.  

Total = $7,349,062
Table C. MHBG Funding for Transformation Activities  
State: Wisconsin

<table>
<thead>
<tr>
<th>GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
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<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td>If yes, please provide the actual or estimated amount of MHBG funding that will be used to support this transformation goal in FY2010</td>
<td>Estimated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOAL 2: Mental Health Care is Consumer and Family Driven</td>
<td>✗</td>
<td>75,000</td>
</tr>
<tr>
<td>GOAL 3: Disparities in Mental Health Services are Eliminated</td>
<td>✗</td>
<td>1,103,629</td>
</tr>
<tr>
<td>GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice</td>
<td>✗</td>
<td>491,042</td>
</tr>
<tr>
<td>GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*</td>
<td>✗</td>
<td>501,827</td>
</tr>
<tr>
<td>GOAL 6: Technology Is Used to Access Mental Health Care and Information</td>
<td>✗</td>
<td>111,615</td>
</tr>
<tr>
<td><strong>Total MHBG Funds</strong></td>
<td>N/A</td>
<td>2,463,113</td>
</tr>
</tbody>
</table>

*Goal 5 of the Final Report of the President’s New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.
Wisconsin

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State’s transformation activities are described elsewhere in this application, you may simply refer to that section(s).
Description of Transformation Activities in Table C

Goal 1: Americans Understand that Mental Health is Essential to Overall Health $75,000

Wisconsin Protection and Advocacy $75,000
See section "Description of Regional Resources" for information on protection and advocacy.

Goal 2: Mental Health is Consumer and Family Driven $1,103,629

Family/Consumer Self-Help and Peer to Peer Support Programs $991,629
See section "State's Vision for the Future" (Children and Adults) and "Recent Significant Achievements" (Adults) for information on consumer recovery activities.

Consumer/Family Stipends and Expenses to Facilitate their Participation in Statewide Mental Health Planning and Policy Meetings $25,000
See section "State's Vision for the Future" (Children and Adults) for information on consumer recovery activities.

Geropsychiatry Training and Stipends for Elderly Consumer Participation $5,000
See sections "Older Adults" and "State's Vision for the Future" (Adults) for information on geropsychiatry training and elderly consumer participation.

Recovery Technical Assistance $82,000
See section "State's Vision for the Future" (Children and Adults) for information on consumer recovery activities.

Goal 3: Disparities in Mental Health Services are Eliminated $491,042

Promote Trauma Informed Systems $60,000
See section "Available Services" (Adults) for information on the trauma informed care initiative in Wisconsin.

Tribal Best Practices in Co-Occurring Disorders $100,000
See section "Available Services" (Adults) for information on Tribal best practices in co-occurring disorders.

Homeless Access to MH Services $74,000
See section "Outreach to Homeless" (Children and Adults) for information on access to mental health services for homeless individuals in the state.

Workforce Development/Psych Consultation $257,042
See section "Rural Area Services" and "Plans to Address Unmet Needs" (Children and Adults) for information on workforce development and psychiatric consultation.
Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice $180,000

Child Welfare Screening $60,000
See section "Recent Significant Achievements" (Children) for information on child welfare screening.

Prevention and Early Intervention $95,000
See section "Plans to Address Unmet Needs" (Children) for information on prevention and early intervention.

Infant Mental Health $25,000
See "State's Vision for the Future" (Children) for infant mental health activities taking place in the state.

Goal 5: Excellent Mental Health Care is Delivered and Programs are Evaluated $501,827

County QI/EBPs Development $118,000
See sections "Goals, Targets and Action Plans," "State's Vision for the Future," and "Recent Achievements" (Adults and Children) for information on evidence-based program development.

County QI-Continuity of Care Project $69,702
See sections "Goals, Targets and Action Plans" and "State's Vision for the Future" (Adults and Children) for information on evidence-based program development.

Promote EBPs for Children $27,927
See sections "Goals, Targets and Action Plans, "State's Vision for the Future," and "Recent Achievements" (Adults and Children) for information on evidence-based program development.

Children's ISP/CST Training, Crisis Network and Conference $32,000
For information on ISP/CST training, see section "Available Services" (Children). For information on the crisis network and conference, see section "Emergency Service Provider Training" (Adults and Children).

Technical Assistance on Reducing Seclusion and Restraint $25,000
See sections "Recent Significant Achievements" and "Available Services" (Children) for information on technical assistance to reduce seclusion and restraint.

Training for Schools on Promoting Positive Behavior Supports $22,958
See sections "Recent Significant Achievements" and "Available Services" (Children) for information on training for schools on promoting positive behavior supports.
CCS Coordinator $66,240
See section "Available Services" for information on Comprehensive Community Services (CCS).

CCS Development $100,000
See section "Available Services" for information on CCS.

TA Elder Care $30,000
See sections "Older Adults" and "State's Vision for the Future" (Adults) for information on elder care technical assistance.

Bureau of Prevention Treatment and Recovery Conference $10,000
See sections "Available Services" (Adults) and "Resources for Providers" (Children and Adults) for information on BPTR conference.

Goal 6: Technology Is Used to Access Mental Health Care and Information $111,615

NOMS Data Collection/Evaluation $61,615
See section "Goals, Targets and Action Plans" (Children and Adults) for information on NOMS data collection and evaluation.

BITS/HSRS Data Changes $50,000
See section "Goals, Targets and Action Plans" (Children and Adults) for information on BITS/Human Services Reporting System (HSRS) data changes.

Total=$2,463,113
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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</thead>
<tbody>
<tr>
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<td>79,514</td>
<td>82,309</td>
<td>86,424</td>
<td>87,247</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
<td>--</td>
<td>--</td>
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</tr>
</tbody>
</table>

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 by one percent the number of adults served through the public mental health system annually.

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 2010.

Measure: Number of adults 18 and older receiving mental health services through the public mental health system in FFY 2010.

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 we are required to report in the annual Implementation Report. The Implementation Report in which Wisconsin reports on this indicator is due to be completed December 1, 2009.

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 in this section.

Action Plan: In FFY 2009, Wisconsin will use a number of different methods to increase the number of adults 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 has increased the number of certified CCS programs in the state on an annual basis by providing $186,900 in program start-up funds. To date, 27 counties have received certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) Wisconsin uses the same funding for counties who wish to start a new Community Support Program (CSP). DMHSAS provided start-up funding and technical assistance to Iron County over a two-year period to assist them to hire staff and meet the program requirements necessary to obtain certification, begin serving clients and billing Medical Assistance for services provided to Medicaid eligible clients under their Community Support Program. Walworth County also obtained certification for their CSP, and although they did not request start-up funding, the state provided technical assistance.

Of the eight counties remaining without a CSP, seven are rural counties. In FFY 2010, Wisconsin plans to offer up to $186,900 in GPR and $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.
Implementing tele-health (described in Criterion 4) will also provide a vehicle for expanded mental health services in rural parts of the state where these services are currently unavailable. 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. A three-pronged approach will be used: (a) a tele-health clinic 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).
**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>9.91</td>
<td>11.37</td>
<td>10</td>
<td>9</td>
<td>8</td>
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<tr>
<td>Numerator</td>
<td>876</td>
<td>1,073</td>
<td>--</td>
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</tr>
<tr>
<td>Denominator</td>
<td>8,839</td>
<td>9,441</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**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 2010 who are readmitted within 30 days.

**Measure:**
Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days.
Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010.

**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.

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 Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.

**Action Plan:** Wisconsin projects an annual decrease of approximately one percent in the 30-day readmission
rate over the FFY 2010 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 readmissions to psychiatric hospitals by making more services more readily available in the community.

*To date, 27 counties have received CCS certification through the Division of Quality Assurance (DQA) (Milwaukee decided not to operate a CCS program after they were certified.) 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 elders whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by CSPs.

*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.

*The availability of 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.

*Work will begin in the fall of 2009 on revision of the Community Support Program Administrative Rule for Wisconsin. The Recovery Implementation Task Force has recommended that the utilization of the SAMHSA ACT toolkit be required of all certified CSPs. This will improve fidelity of Wisconsin CSPs to the ACT evidence-based model.
### Transformation Activities:

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
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<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
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<td></td>
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<tr>
<td>Denominator</td>
<td></td>
<td>8,839</td>
<td>9,441</td>
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</tbody>
</table>

**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 2010 who are readmitted within 180 days.

**Measure:**
- Numerator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days.
- Denominator: The number of adults discharged from all state and county psychiatric hospitals in FFY 2010.

**Sources of Information:** 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.

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 Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.

**Action Plan:** Wisconsin projects an annual decrease of approximately 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. 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 CCS benefit expands the availability of outpatient MA-funded mental health services. To date, 27 counties have received certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) Comprehensive Community Services (CCS) benefits complement those provided by existing CSPs by offering 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 elders whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by CSPs.

*Increasing the number of crisis programs through the five multi-county initiatives has also 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.

*The availability of 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. Between CCS and CSP certified programs only five rural counties remain without a comprehensive community program beyond case management for SMI individuals.

*Work will begin in the fall of 2009 on revision of the Community Support Program Administrative Rule for Wisconsin. The Recovery Implementation Task Force has recommended that the utilization of the SAMHSA ACT toolkit be required of all certified CSPs. This will improve fidelity of Wisconsin CSPs to the ACT evidence-base model.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
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<td>N/A</td>
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<tr>
<td>FY 2008 Actual</td>
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<tr>
<td>FY 2009 Projected</td>
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<td>--</td>
</tr>
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<tr>
<td>FY 2011 Target</td>
<td>7</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Transformation Activities:

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 2010.

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 2010.

Measure: Number of evidence-based practices used for adults in the state in FFY 2010.

Sources of Information: 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.

Action Plan: 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. As described earlier, the CSPs are 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 Emplyment, IMR, and Seeking Safety groups for both men and women. Brown and Marathon counties are implementing IDDT, 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.
**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
</thead>
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</tr>
<tr>
<td>Denominator</td>
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<td>5,540</td>
<td>--</td>
<td>--</td>
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</tr>
</tbody>
</table>

**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 annually.

**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 Community Support Programs in FFY 2010.

**Measure:**
- Numerator: Number of adults receiving Supported Housing as an evidence-based practice in the state in FFY 2010.
- Denominator: Number of adults served through CSPs in the state in FFY 2010.

**Sources of Information:** Community Support Program Survey data.

**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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.

**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.

**Action Plan:** The BPTR formed an EBP work group in August 2007 to formally define EBP’s 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 such schemes as 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 EBP’s 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 housing, but the degree to which is being implemented with complete fidelity to the Supported Housing 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 EBP’s or best practices. The EBP work group’s efforts will help determine which local providers are already using Supported Housing 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 Housing 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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 Psychoeducation 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.
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 within Community Support Programs by one percent as an evidence-based practice for adults by funding their implementation and disseminating training resources.

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 2010.


Sources of Information: Community Support Program Survey data.

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.

Action Plan: The BPTR formed an EBP work group in August 2007 to formally define EBP’s and to help coordinate the various EBPs 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 such schemes as 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 EBP’s 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 EBP’s 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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.
ADULT - GOALS TARGETS AND ACTION PLANS

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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<td>Denominator</td>
<td>5,541</td>
<td>5,541</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: To facilitate the use of evidence-based practices for adults. (National Outcome Measure)
Target: To increase the use of evidence-based practices for adults served through Community Support Programs by one percent annually.
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 the state in FFY 2010.
Measure: Numerator: Number of adults being served through the ACT model in Community Support Programs in FFY 2010. Denominator: Number of adults served through Community Support Programs in FFY 2010.
Sources of Information: Community Support Program Survey.
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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.

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.
Action Plan: 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. As described earlier, the CSPs are based on the ACT model.

The BPTR formed an EBP work group in August 2007 to formally define EBP’s 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 such schemes as 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 EBP’s 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
EBP’s 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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 Psychoeducation 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.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

<table>
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<th>(1)</th>
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<th>(5)</th>
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<td>Fiscal Year</td>
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<td>FY 2008 Actual</td>
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<td>FY 2010 Target</td>
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<td>Denominator</td>
<td>5,540</td>
<td>5,540</td>
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</tbody>
</table>

Table Descriptors:

Goal: To facilitate the use of Family Psychoeducation as an evidence-based practice for adults.

Target: Increase the use of Family Psychoeducation as an evidence-based practice for adults in Community Support Programs by one percent annually.

Population: Adults with SMI.

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

Indicator: Percentage of adults receiving Family Psychoeducation through Community Support Programs in FFY 2010.

Measure: Numerator: Number of adults receiving Family Psychoeducation through Community Support Programs in FFY 2010.
Denominator: Number of adults served through Community Support Programs in FFY 2010.

Sources of Information: Community Support Program Survey data.

Special Issues: Training for Family Psychoeducation was offered via contract for local providers in CY 2007 for the first time. It is unclear how many CSP staff were trained from 2007-2009. As better data becomes available, more accurate counts will be possible.

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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.

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.

Action Plan: The BPTR formed an EBP work group in August 2007 to formally define EBP’s 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 such schemes as 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 EBP’s 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 Family Psychoeducation, but the degree to which is being implemented with complete fidelity to the Family Psychoeducation 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 EBP’s or best practices. The EBP work group’s efforts will help determine which local providers are already using Family Psychoeducation and thus the reporting for this EBP could...
change in the future. Presently, the CSPs self-report on the number of individuals receiving the Family Psychoeducation 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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 Psychoeducation 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.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

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<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
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<td>(FY 2008 Actual)</td>
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<td>904</td>
<td>5,541</td>
</tr>
<tr>
<td>(FY 2009 Projected)</td>
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<td>--</td>
</tr>
<tr>
<td>(FY 2010 Target)</td>
<td>20</td>
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<td>--</td>
</tr>
<tr>
<td>(FY 2011 Target)</td>
<td>22</td>
<td>--</td>
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</tr>
</tbody>
</table>

Table Descriptors:

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

Target: To increase the use of IDDT within Community Support Programs by two percent as an evidence-based practice for adults by funding their implementation and disseminating training resources.

Population: Adults with SMI.

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

Indicator: Percentage of adults receiving IDDT as an evidence-based practice in Community Support Programs in FFY 2010.

Measure: Numerator: Number of adults receiving IDDT as an evidence-based practice in Community Support Programs in FFY 2010.
Denominator: Number of adults served in Community Support Programs in FFY 2010.

Sources of Information: Community Support Program Survey data.

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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.

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.

Action Plan: 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 such schemes as 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 EBP’s 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 IDDT, but the degree to which is being implemented with complete fidelity to the IDDT 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 EBP’s or best practices. The EBP work group’s efforts will help determine which local providers are already using IDDT 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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 Psychoeducation 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.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
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<tr>
<td>Denominator</td>
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</tr>
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</table>

Table Descriptors:

Goal:
To facilitate 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 by one percent annually.

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 in FFY 2010.

Measure:
Numerators: The number of adults receiving Illness Self-Management services through Community Support Programs in FFY 2010.
Denominators: The number of adults receiving services through Community Support Programs in FFY 2010.

Sources of Information:
Community Support Program Survey data.

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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.

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.

Action Plan:
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 such schemes as 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 Illness Self-Management, but the degree to which is being implemented with complete fidelity to the Illness Self-Management 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 Illness Self-Management and thus the reporting for this EBP could change in the future. Presently, the CSPs self-report on the number of individuals receiving the Illness Self-Management 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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.
Transformation Activities:

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

<table>
<thead>
<tr>
<th>(1)</th>
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<th>(6)</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
</tr>
<tr>
<td>44.13</td>
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<td>Denominator</td>
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</tr>
</tbody>
</table>

Table Descriptors:

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

**Target:** Increase the use of Medication Management as an evidence-based practice for adults served through Community Support Programs by one percent in FFY 2010.

**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 Community Support Programs in FFY 2010.

**Measure:**
- **Numerator:** Number of adults receiving Medication Management as an evidence-based practice in Community Support Programs in FFY 2010.
- **Denominator:** Number of adults served through Community Support Programs in 2010.

**Sources of Information:** Community Support Program Survey data.

**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.

*2008 CSP Survey data will be available in January of 2010. Presently, 2007 data is in the 2008 field as a placeholder.*

**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.

**Action Plan:** The BPTR formed an EBP work group in August 2007 to formally define EBP’s 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 such schemes as 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 EBP’s 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 Medication Management, but the degree to which is being implemented with complete fidelity to the Medication Management 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 EBP’s or best practices. The EBP work group’s efforts will help determine which local providers are already using Medication Management and thus the reporting for this EBP could change in the future. Presently, the CSPs self-report on the number of individuals receiving the Medication Management 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 serve eight residents in a local Supportive Housing Program. Jefferson County reports that in 2007, 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.
**ADULT - GOALS TARGETS AND ACTION PLANS**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
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<td>63.14</td>
<td>65</td>
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<tr>
<td>Performance Indicator</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>355</td>
<td>369</td>
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</tr>
</tbody>
</table>

**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 of 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 2010.

**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.

**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.

**Action Plan:**
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 toward 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 began in five counties in FFY 2008 and was offered to an expanding number of counties.
in 2009 to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance. In 2008, money from the MHBG 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 will allow additional counties in FFY 2010 to collect data at the local level that they can use as indicators of annual progress in recovery.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
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<td>Denominator</td>
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</table>

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 2010.

Measure: Numerator: Number of adults 18 and older with SMI who are employed in FFY 2010. Denominator: Number of adults 18 and older with SMI who are employed, unemployed, or not in the labor force in FFY 2010.

Sources of Information: 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.

Action Plan: 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.
Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
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<td>FY 2008 Actual</td>
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<td>13</td>
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<td>FY 2009 Projected</td>
<td>27</td>
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<td>FY 2010 Target</td>
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<td>--</td>
</tr>
<tr>
<td>FY 2011 Target</td>
<td>21</td>
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</tbody>
</table>

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 three 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 2010 after being arrested in FFY 2009.

Measure: Numerator: Number of adults 18 years and older with SMI who were arrested again in FFY 2010 after being arrested in FFY 2009.
Denominator: Number of adults 18 years and older with SMI who were arrested 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 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 2009 or FFY 2010. The indicator focuses on adults arrested in FFY 2009 to see if they were able to avoid being arrested again in FFY 2010.

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.

Action Plan: 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.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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</thead>
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</tr>
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</table>

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.

Population: Adults with SMI.

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

Indicator: The change in percentage of adults with SMI who are homeless who receive mental health services in FFY 2010.

Measure: Numerator: Number of adults with SMI who are homeless who receive mental health services in FFY 2010 minus the number of adults with SMI who are homeless who receive mental health services in FFY 2010.
         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 2010 MHBG funds in CY 2010. 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.

Action Plan: 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 2009 informing counties to continue to prioritize individuals who are homeless for mental health services with the use of their FFY 2010 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.
**Transformation Activities:**

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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</thead>
<tbody>
<tr>
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<td>Denominator</td>
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<td>376</td>
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**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 2010.

**Measure:**

Numerator: Number of adults 18 and older with SMI who agree they have social supports to rely on in their community in FFY 2010.
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 2010.

**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.

**Action Plan:**

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 PSR requirements this is the ideal time to promote training and technical assistance for person centered planning for all mental health programs in Wisconsin. In 2008, DMHSAS had the
opportunity to apply for technical assistance from the Substance Abuse and Mental Health Services Division (SAMHSA) of the Federal Department of Health and Human Services. The technical assistance Wisconsin chose was Person Centered Approaches to Planning. The training, designed by Neal Adams, M.D., M.P.H. and Diane Grieder, M.Ed. is based on the book written by Dr. Adams and Ms. Grieder, called Treatment Planning for Person Centered Care: The Road to Mental Health and Addiction Recovery. Their book responds to the call for systems transformation and change that is challenging today’s behavioral health environment. They propose a new approach to the use of treatment plans as a vehicle for individual and systems change as well as providing more effective behavioral healthcare. DMHSAS arranged the first training with five initial county agencies and their staff in FFY 2008. With the CMS grant they will be able to cover the state in three years. Without the grant DMHSAS will invest in a train the trainer model with the initial five counties and use a mentoring/training approach a little more slowly across the state. Given the new CMS approach to PSR and the support of SAMHSA to meet the NFC goals we anticipate better responses in the future to the survey asking about community connectedness.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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Table Descriptors:

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

Target: To increase the percentage of consumers with improved functioning by two 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 FY 2010.

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 FY 2010.
Denominator: Number of adults 18 and older with SMI responding about their general ability to function on the MHSIP satisfaction survey in FY 2010.

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 five-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.

Action Plan: 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 an 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.
Name of Performance Indicator: Access to MH services for adults with a SMI in rural areas.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
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<td>58</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: To increase access to mental health services for adults with a SMI in rural areas.
Target: Increase by two percent annually the number of rural counties with a CSP.
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 2010. Denominator: The number of rural counties in FFY 2010.

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

Special Issues: There are currently eight counties which do not have a CSP and all but one are rural. Another county will be selected in FFY 2010 for CSP expansion.

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

Action Plan: 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. The program uses an Assertive Community Treatment (ACT) approach, which was developed at the Mendota Mental Health Institute in Wisconsin. The CSP Program has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, rehabilitation, crisis, and supportive services. CSPs serve persons who have a serious mental illness that affects both their ability to live independently in the community and to function in major life roles. The mobility of the program staff make outreach to individuals in rural areas possible.

The array of required treatment services available to CSP consumers include: case management, crisis intervention, symptom assessment, medication management and education, medication prescribing and monitoring, psychiatric evaluation and treatment, and family, individual or group psychotherapy. The required 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.

DMHSAS provided start-up funding and technical assistance to Iron county over a two-year period to assist them to hire staff and meet the program requirements necessary to obtain certification, begin serving clients and billing Medical Assistance for services provided to Medicaid eligible clients under their Community Support Program. Walworth County also obtained certification for their CSP, and although they did not request start-up funding, the state provided technical assistance.
Of the eight counties remaining without a CSP, seven are rural counties. In FFY 2010, Wisconsin plans to provide $100,000 in MHBG funds for start-ups 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.
## Name of Performance Indicator: Adults Receiving Evidence-Based Practices

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</table>

### Transformation Activities:

- ✔️

### Table Descriptors:

#### Goal:
To facilitate the use of evidence-based practices for adults.

#### Target:
To increase the use of evidence-based practices for adults by funding their implementation and disseminating training resources in FFY 2010.

#### Population:
Adults with SMI.

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

#### Indicator:
Number of adults receiving evidence-based practices in the state in FFY 2010.

#### Measure:
Number of adults receiving evidence-based practices in the state in FFY 2010.

#### Sources of Information:
CSP Monitoring Report for ACT reporting. Individual county reports on consumers served with other EBPs. Other sources to be determined.

#### Special Issues:
The first task for Wisconsin is collecting reliable statewide data on the use of evidence-based practices. 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.

### Action Plan:
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. As described earlier, CSPs are based on the ACT model. A web-based survey on numbers of EBPs being implemented through Community Support Programs (CSP) in the state was implemented beginning in 2007. In 2008, counties reported that 6,820 individuals with serious mental illness were receiving EBPs through CSPs.

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 2009 their local CSP and CCS are implementing 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. Richland County is implementing IMR.

The EBP grants were awarded in 2008 to help 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 has 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 of information on the implementation of EBPs.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Expansion of the mental health and co-occurring functional screen.

<table>
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<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
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<td>72</td>
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Table Descriptors:

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

Target: To increase the use of the MH/AODA Functional Screen in additional counties by five percent annually.

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

Criterion: 2:Mental Health System Data Epidemiology

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

Measure: Numerator: Number of counties implementing the MH/AODA Functional Screen in FFY 2010. Denominator: Total number of counties in Wisconsin.

Sources of Information: MH/SA Functional Screen data.

Special Issues: Thirty or more initial and annual screens.

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.

Action Plan: 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 provides DMHSAS with 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.
Name of Performance Indicator: Implement New CCS Programs

<table>
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<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
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</table>

Table Descriptors:

Goal: Implement new CCS programs to increase funding for an expanded array of services.

Target: To implement the CCS benefit in an additional three percent of Wisconsin's counties annually.

Population: Adults and elders with SMI.

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

Indicator: Percentage of counties in Wisconsin who implement the CCS benefit in FFY 2010.

Measure: Numerator: The number of counties who implement the CCS benefit in FFY 2010.
           Denominator: The total number of Wisconsin counties in FFY 2010.

Sources of Information: State data on counties who become certified to provide the CCS benefit.

Special Issues: None.

Significance: CCS is becoming a strong component of Wisconsin's comprehensive service continuum as more counties become certified to provide CCS every year in addition to their CSP. CCS is a Medicaid-funded service which should increase the number of consumers with access to flexible services for recovery. This is an important development in Wisconsin’s service array.

Action Plan: To date, 27 counties have received certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 elders whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by CSPs. 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.

It is anticipated that annually approximately four to five counties will become certified. To further facilitate start-up and proper implementation, the DMHSAS will annually award $100,000 in MHBG funds to developing CCS or CSP programs. These counties are able to fund trainings and CCS program personnel, train consumers and fund consumers on their coordination committees for example, to accelerate their implementation of the program.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increase Access to MH Services through CCS

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<thead>
<tr>
<th>(1)</th>
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Table Descriptors:

Goal: Increase access to mental health services by expanding the use of the CCS benefit in counties.

Target: To increase the number of consumers served in CCS programs by 10 percent annually.

Population: Adults with SMI.

Criterion: 2: Mental Health System Data Epidemiology

Indicator: The percentage change in the number of adult consumers served in Wisconsin in CCS programs from FFY 2009 to FFY 2010.

Measure: Numerator: Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2010 minus the number of adults 18 and older receiving CCS services through the public mental health system in FFY 2009.
Denominator: Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2009.

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

Special Issues: Although CCS is a Medicaid benefit and thus almost all CCS recipients would be recorded in the state Medicaid database, all consumers served should also be recorded in the HSRS database. All CCS recipients are served within the public mental health system and all public mental health service recipients are recorded in the HSRS data.

Significance: CCS began as a Medicaid benefit in 2005 for the provision of psychosocial rehabilitation services. Although not funded through Medicaid previously, CCS is not a new component to the Wisconsin mental health system. However, its availability as a Medicaid-reimbursable benefit is expected to increase its use by providers to serve more consumers with a level of need appropriate for CCS. This is an important development in Wisconsin's service array.

Action Plan:
To date, 27 counties have received certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) The number of consumers served in CCS programs increased in the first two years of the availability of the Medicaid CCS benefit. After an initial 229 consumers were served in FFY 2006, an additional 520 consumers were served in FFY 2007, which was an increase of 227 percent. Given there were no additional CCS programs certified in FFY 2008, the increase in CCS consumers served was due to increased capacity of existing CCS programs. Based on consumers served in 2008, the expected additional consumers served in each new CCS program in 2009 are about 40. The objective is set at 10 percent currently because the large increases in CCS consumers served in the first couple years of the program's development is not expected to be maintained.

State staff will continue to provide training and technical assistance to these counties, as well as providing assistance to other counties that have expressed an interest in becoming certified. Wisconsin employs a full-time CCS Statewide Coordinator to aid in the training and technical assistance as well as in the certification approval process. Extensive technical assistance is required for each CCS program to prepare them for certification and to maintain the certification. To further facilitate start-up and proper implementation, the DMHSAS will
annually award $100,000 in MHBG funds to develop CCS and CSP programs. These counties are able to fund trainings and CCS program personnel, for example, to accelerate their implementation of the program. The number of additional counties becoming certified annually will eventually decline as the initial surge of interested counties passes. It should be noted that CCS services people who have mental health issues that need services and supports beyond outpatient services, but the population is demographically different than the CSP population. This population was previously served primarily in the targeted case management programs, where services were limited to the coordination of care. CCS allows for a greater breadth of services for this population promoting consumer focused recovery.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Resources for consumer support programs.

<table>
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<tr>
<th></th>
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<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
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Table Descriptors:

Goal: Maintain resources to consumer-run programs and services and to family support services.

Target: Maintain funding for consumer and family programs and services.

Population: Consumers and family members.

Criterion: 5:Management Systems

Indicator: Change in the amount of funds allocated to family support and consumer-run programs, services and training in FFY 2010.

Measure: FFY 2010 funds allocated to consumer-run and family support programs allocated to consumer-run and family support programs.

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 2010. 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.

Action Plan: 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 occurred in FFY 2009 to provide services in the same areas of adult consumer support, adult and family consumer support, and child and family support and will continue in FFY 2010.
Wisconsin

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 1: Comprehensive Community-Based Mental Health Services

Directions: Provides for the establishment and implementation of an organized community-based system of care for individuals with severe mental illness.

Establishment of System of Care

Wisconsin's Continuum of Care

Wisconsin’s comprehensive recovery-based mental health system provides a continuum of care which begins with prevention and places its emphasis on services based in the community. The continuum continues across the lifespan with more intensive services, including providing services in residential and inpatient settings where appropriate to the needs of the individual. The continuum also provides other services which help people attain their recovery goals, including medical and dental, educational, employment, housing, and support services, and services targeted at special populations, such as older adults, the deaf and hard of hearing population, the homeless and individuals with both mental health and physical conditions requiring treatment and support.

Community-Based Services

Outpatient Mental Health Services

Psychotherapy, evaluation, counseling/therapies, and psychopharmacologic management are provided to individuals with mental health problems on an appointment basis. These individuals are typically not in need of more intense hospital services or ongoing daily monitoring to prevent deterioration of their mental health. This service is provided through a certified clinic that provides comprehensive professional services by psychiatrists, psychologists, and master level therapists. Medicaid state funding provides the non-federal share of these services in clinic or institutional settings, and counties provide the match to federal financial participation (FFP) for intensive outpatient mental health services provided in a home or community setting. (Intensive outpatient mental health services include: Community Support Programs; Comprehensive Community Services Programs; Targeted Case Management services; Crisis Intervention Services; and In-home/Community services for adults.) Psychologists and psychiatrists also provide these services in independent private practice. Over 818 public and private clinics are certified by the state and provide services to over 70,000 individuals in the public mental health system annually, in addition to thousands of persons who are not in the public system. 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://ww.legis.state.wi.us/rsb/code/dhs/dhs035.pdf

*For more detail on revision of the outpatient rule, see Adult Section "Legislative Initiatives and Changes."

**Community Support Programs**

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 severe mental illnesses. The program uses an Assertive Community Treatment (ACT) model, which was developed at the Mendota Mental Health Institute in Wisconsin. The ACT model has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, rehabilitation, crisis, and supportive services. CSPs serve persons who have a serious severe mental illness that affects both their ability to live independently in the community and to function in major life roles.

The array of required treatment services available to CSP consumers include: case management; crisis intervention; symptom assessment; medication management and education; medication prescribing and monitoring; psychiatric evaluation and treatment; and family, individual or group psychotherapy. The required 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.

The state provides funding for CSPs through community aids and Mental Health Block Grant (MHBG) funds. In addition, Wisconsin Act 16 appropriates $1,000,000 state General Purpose Revenue (GPR) funds annually to improve access to CSPs using it to match federal funding for individuals eligible for Medicaid.

The Division of Mental Health and Substance Abuse Services (DMHSAS) makes direct GPR funding available to counties interested in establishing a certified CSP, and provides technical assistance to meet the criteria for ACT laid out in Administrative Rule DHS 63. In 2006, Iron County was given $80,000 to establish a new CSP, and obtained provisional CSP certification early in 2007. Some examples of service delivery development include: local systems change to provide for comprehensive access; a fluid continuum of care; revision of assessment and care plan processes and forms to assure they are recovery-based; processes that involve the consumer at all points in the process of creating a treatment plan; staff training in outcomes, trauma-informed treatment and recovery-based treatment; and, determining how outcomes for consumers and general quality service delivery will be measured at the local level.

By spring 2008 there were 78 CSPs in Wisconsin (see map, below) which meet the standards for CSP certification established by the DHS. In CY 2007, CSPs served 5,771 persons. DMHSAS will continue its efforts to promote program certification in counties without a certified CSP.
As noted previously, case management is an integral part of Wisconsin's services. All of Wisconsin counties provide some level of case management for persons who have a serious severe mental illness.

**Targeted Case Management**

Targeted case management is a mechanism for coordinating and arranging services. It includes ensuring comprehensive assessment and regular reviews of assessment and recovery plans, follow-up and monitoring of referrals, coordination of services available at the local level, and coordination of crisis services. Each county provides case management, which is a linkage connecting individuals to services provided by multiple mental health, housing, or rehabilitation programs in the community. For MA recipients, counties may bill the MA program for targeted case management services, and the county provides the match to FFP from non-federal funds.

**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.

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

**Nursing Home Relocation Planning**

Wisconsin received two grants from the Centers for Medicare and Medicaid Services; a Real Choice Systems Grant and a New Freedom Initiative Grant. The DMHSAS has identified key nursing facilities that have significant numbers of residents with mental health diagnosis and that have expressed willingness to jointly plan with county staff for community placement. One goal is to ensure that the system incorporates best practice models that include comprehensive, recovery-based assessment and planning. Relocation involvement at the time of facility closure or downsizing is also actively pursued as a time to provide technical assistance regarding community placement options. In January 2007 Wisconsin received approval of its proposal for a Money Follows the Person Demonstration Grant.
The Community Opportunities and Recovery (COR) is a relocation waiver for people living with serious severe mental illness and a co-occurring physical disability in a nursing home and want to move to the community. Due to the amount of time it took to develop the governing policies, procedures and the corresponding manual materials for this new 1915 (c) home and community based services waiver, the effective date was amended with the Centers for Medicare and Medicaid Services (CMS) to January 1, 2008.

Numerous meetings and contacts were made with those counties who had not already transitioned to Family Care. (Once Family Care is implemented in a county, the COR waiver is wrapped into it and no new participants are enrolled in COR.) During 2008, Dane County successfully implemented the COR waiver and relocated four individuals from their county operated nursing home. None of these four individuals were eligible for the Money Follows the Person Project.
Wisconsin

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 1. Comprehensive Community-Based Mental Health Services

Directions: Describes available services and resources in a comprehensive system of care including systems for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and other activities leading to reduction of hospitalization.

Available Services Children

Health, Mental Health, And Rehabilitation Services

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 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.
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 new services are known as Comprehensive Community Services (CCS). The new rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to both children and adults, including elders, 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. 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 coordinating committee's participation in the development of the CCS program. They 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.

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 development of 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 will include 1/3 consumer membership.

To date, 27 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 addition to the CCS initiative which serves mental health consumers across the lifespan, the Coordinated Services Team (CST) initiative focuses on children involved in multiple systems and in need of mental health and substance abuse services.

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.

**Wisconsin’s Continuum of Care**

Wisconsin’s mental health system for children provides a continuum of care which begins with prevention and places its emphasis on services based in the community. The continuum continues with more intensive services, including services in residential and inpatient settings where appropriate to the needs of the individual. The continuum also provides other recovery-oriented services, including medical and educational, employment, housing, and support services. Dental services are also covered.

**Prevention and Early Intervention**

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

**Mental Health America of Wisconsin**

Mental Health America of Wisconsin is the lead contracted agency for MHBG-funded prevention and early intervention activities. MHA is one of 320 local affiliates of National Mental Health America. The MHA of Wisconsin has 18 employees, three offices statewide with their primary
office in Milwaukee, and a budget of more than $1.4 million. The nonprofit organization is
dedicated to helping all people live mentally healthier lives. Their mission is to promote mental
health, prevent mental disorders, and achieve victory over mental illness through advocacy,
education, information, and support.*

*For Detailed Information on Implementation of the Garrett Lee Smith Memorial Youth
Suicide Prevention Grant through MHA see Section "Available Services--Adults."

**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 to local early childhood multi-system groups regarding
development of community infant mental health plans
- Held first state-wide infant and early childhood mental health conference

Selected goals for 2009-2010 include:
- Standardization of screening objectives across diverse divisions and systems of care
- Integration of children's mental health and primary health care services
- Full implementation of DC:0-3R in Wisconsin
- Provision of training and technical assistance on DC:0-3R
- Implementing an IMH endorsement process for professionals across disciplines and systems

**IMHLT POLICY RECOMMENDATIONS**

1. Early identification of social emotional delays in children under the age of five should be
implemented through a universal screening DHS protocol.
2. Utilization of DC:0-3R should be encouraged and monitored. Technical assistance should be provided based on data showing need for increased capacity or training, including need for training within state departments.

3. Information on early childhood mental health should be disseminated to mental health providers, early childhood workers, public policy makers and other stakeholders.

4. Infant and early childhood principles and practices should be integrated across Divisions in DHS as well as other Departments and stakeholders.

*See "State's Vision for the Future" section for more information on the use of DC:0-3R in Wisconsin, and acquiring the Michigan Endorsement Process for Infant Mental Health Providers in the state.

**See "Plans to Address Unmet Needs" section for information on DC:0-3R training that occurred in Wisconsin in 2008.

Seclusion and Restraint

Over the last ten years, the use of seclusion and restraint has received national attention, has come under increased scrutiny and many States and programs have implemented measures to reduce its use and provide training to staff to develop positive behavior reinforcement skills in de-escalating situations that might end up being physical. It has been clearly recognized that physical restraint is an inherently dangerous practice, not only for the child being restrained, but for the staff who are enforcing it. In addition, it has been reported that for many children the practice of seclusion and restraint is detrimental for it often traumatizes the child, can damage therapeutic relationships, and can impede recovery. Lastly, its use can result in serious liability concerns for the programs in which it occurs. Many national organizations and governmental entities have raised concerns about deaths and injuries that have resulted from its use and question its effectiveness as a treatment modality particularly when it is imposed as a "means of coercion, discipline, convenience, or retaliation by staff."

The Wisconsin Department of Health Services (DHS) has gone on record regarding the detrimental effects of these coercive activities, convened workgroups to reduce their use, and over the past 15 months has sponsored three training programs for approximately 22 providers and 460 participants that have focused on the goal of reducing seclusion and restraint in community-based programs regulated by DHS and the Department of Children and Families (DCF).

The Disability Rights Report (DRW) report “A Tragic Result of a Failure to Act: The Death of Angellika Arndt” was released in December 2008. The report addressed the May 31, 2006 death of Angellika Arndt that was directly related to restraint at a day treatment facility. While this report recognized DHS/DCF efforts, it also challenged the Departments to do more and move faster.

Karen Timberlake, the Secretary of the Department of Health Services agreed with many recommendations of the report and renewed the DHS commitment to this important issue. On March 13, Secretary Timberlake responded to DRW agreeing to act on most of the 16 recommendations of the report.

The first action was to issue a memo “The Prohibited Practices in the Application of Emergency Safety Interventions with Children and Adolescents in Community Based Programs and Facilities on March 13, 2009 in collaboration with Reggie Bicha the Secretary of DCF. The purpose of the
memo is to delineate practices that should not at any time be used during the course of an emergency safety intervention. The practices identified in the memo (available at http://dhs.wisconsin.gov/rl_dsl/MentalHealth/bhcsmemo.pdf) are seen as inherently high risk for causing serious injury and possibly death and thus should be avoided.

In addition, in the near future DHS will provide additional guidance to Day Treatment Centers, develop a review process for Day Treatment Centers related to situations where the use of restrictive measures might be appropriate, and continue its training and technical assistance activities. Other DRW recommendations will be studied.

The review process for Day Treatment Centers will be fashioned after the DHS, Division of Long Term Care’s (DLTC) Guidelines and Policies regarding the use of restrictive measures (restraint, isolation, and seclusion). The DLTC process and procedures apply to children funded by any of the Children’s Long Term Support Medicaid Waivers and living in the community. Additionally, the DLTC process includes adults with developmental disabilities served by county waiver agencies or managed care organizations. More about the process and procedures for persons meeting these criteria is located at the following link:
http://dhs.wisconsin.gov/bdds/waivermanual/app_r.htm

Outpatient Services

Outpatient mental health services are provided to many children through Medicaid, BadgerCare or through their county of residence. Some counties employ staff for this purpose and others contract with outside agencies. There are basically two types of outpatient services, the traditional office visit and intensive in-home therapy. Services that are typically provided in the child’s home or a therapist’s office may include, but are not limited to: assessment/diagnosis; treatment, medication planning, monitoring, and review; individual, group, or family counseling/psychotherapy; case management; wraparound coordination; and crisis services. In addition, schools provide services via a child’s Individual Education Plan (IEP) if the child requires special education services.

There are services that may involve a child’s short term, temporary stay in a setting outside their home. Respite services can be provided either in the child’s home, a respite provider’s home, or a facility that offers brief housing and supervision to provide the caregiver temporary relief from the stress of continuous support. For some children, respite is included in their plan of care where the need is clearly established. For example, a child may spend a day every other weekend with a respite provider in the provider’s home to improve their parents’ ability to cope with the demands the child places on the family, or to provide the child a “break” from the home routine. Crisis services can also be provided in the child’s home to stabilize a volatile situation or may involve a child staying in another setting for a short time, usually a few days in a “crisis home” or facility. In the case of both respite and crisis, the facility used often has a different primary purpose, but has a few beds available for county or agency use.

Activities to Reduce Hospitalizations

The effort to reduce the rate of hospitalization for all residents, especially for children who have SED, continues. Even though the rate of inpatient utilization has declined, there has been an increase in service costs at state-operated institutions. Analysis of available data suggests that ISPs have been effective in reducing children’s hospital utilization when compared to counties and tribes without ISPs. Data from counties in the CST Initiative will also be analyzed for reductions in the use of inpatient and other institutional placements. Wraparound Milwaukee and
Dane Children Come First Project have demonstrated successful hospital diversion for several years and were able to become capitated as managed care programs through the Wisconsin Medicaid Program.

Wisconsin has reduced hospital use through Hospital Diversion Program funding (see below); increased utilization of community-based emergency crisis services; telemedicine; and expanded community-based wraparound services. The true challenge lies in ensuring that ongoing hospital reduction is not offset by an increased use of other institutional placements, such as juvenile justice or adult corrections placements.

The DMHSAS is responsible for managing the state’s two mental health institutes: Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute in Winnebago. These facilities provide specialized, acute treatment to children and adolescents, adults, older adults, and forensic mental health consumers, with the long-term goal of reintegration into the community. The institutions provide training and consultation as requested to community-based programs. The number of staffed beds for inpatient care for children and adolescents at state institutions decreased from 112 in 1993 to 84 in 2004; a decrease of 25 percent. An additional 15 beds for specialized Substance Abuse/MI treatment were added in 2004. By July of 2007, 20 beds were transferred to the Centers for people with developmental disabilities, leaving 64 staffed beds for inpatient care for children and adolescents at state institutions. As of April 2009, Mendota Mental Health Institute has 30 child/adolescent beds and Winnebago Mental Health Institute has 49 beds (one 19-bed unit and a 15-bed mixed child/adolescent and a 15-bed adolescent dual diagnosis-substance abuse/mental health-unit). There has also been a reduction in beds in county and privately operated facilities, as units have closed due to decreased demand.

**Hospital Diversion Funding for Children with SED**

Hospital diversion funding goes to selected counties and tribes to help reduce Medicaid inpatient hospital psychiatric spending. This incentive is provided to improve and expand community-based alternatives to institutional care. Hospital diversion funds are authorized in Wisconsin Statute 46.485. During 2005-2007, expanded crisis stabilization programs were funded through hospital diversion funding primarily for children/youth in Winnebago, Fond du Lac and Outagamie Counties. Additional funds have been made available for counties across the state for regional crisis program development. The Eastern Region is targeted for training and consultation to improve their response to kids with challenging behaviors, resulting in more community stabilization and reduced inpatient stays. Hospital Diversion Program funding is also used to expand Coordinated Service Teams (CST) in counties and tribes.

**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.

**Day Treatment**

Wisconsin Administrative code defines day treatment as non-residential care provided on prescription from a physician in a clinically supervised setting. Day treatment programs provide case management and an integrated system of individual, family and group counseling, therapy or other services related to an individually prepared plan of treatment that is based upon a multi-disciplinary assessment of the client and his or her family. The plan is designed to address emotional or behavioral problems experienced by the client related to his or her mental illness or severe emotional disturbance.

Day treatment is a higher level of treatment than other community-based services. Based on the child’s needs, day treatment maintains him/her in the home and in the community by providing part or full day supervision and treatment, usually utilizing group therapy. Some day treatment sites offer education credits and tutoring. An example of the use of day treatment is a supervised teen attends a program offered by a hospital or treatment center where he is supervised, engages in group therapy part of the day, and does school work part of the day.

**Residential Services**

In cases where day treatment services do not provide sufficient supervision and treatment, the usual next step is group home or residential services. As the name implies, children live at the treatment center, often attending school on the grounds, and participate in group and other treatment options addressing severe behavioral or emotional problems. Residential treatment is usually considered long term, (i.e., of several months’ duration). As of June 2007, there are 36 residential treatment facilities licensed by the Department of Children and Families in Wisconsin.

**Inpatient Services**

Wisconsin has several local hospitals and two mental health institutes that serve children with mental health needs that require hospitalization. Over the past 15 years Wisconsin has emphasized the development of community-based mental health services for children and adults. As a result there has been a dramatic shift from institutional treatment to providing local services.
and supports in the community to children with SED and their families. As a consequence, Wisconsin has seen the loss of local inpatient psychiatric bed capacity for children. Several hospitals have closed admissions to children and adolescents and many have cut bed capacity. Even though the overall admissions to all psychiatric beds for children and adolescents have been reduced, especially the length of stays, the two mental health institutes have been operating at capacity or over capacity. Mental health institute beds for children and adolescents have decreased over the past seven years (from 125 beds in 2000 to 79 beds in 2007), while the number of admissions to those beds has increased (832 admissions in FY 00 compared to 974 in FY 07). As of April 2009, Mendota Mental Health Institute has 30 child/adolescent beds and Winnebago Mental Health Institute has 49 beds (one 19-bed unit and a 15-bed mixed child/adolescent and a 15-bed adolescent dual diagnosis-substance abuse/mental health-unit). This is the same number of beds available in 2007 and 2008.

Wisconsin is faced with several challenges in terms of reduced bed capacity and increased demand. The care of children at the state institutes is covered by Medical Assistance, and prior to July 1, 2009, there were no costs to the county. The 2010-2011 state budget requires that counties pick up the non-federal Medicaid cost of children under age 21 and older adults 65 and over placed in state mental health institutes. Care at the institutes has included an increase in substance abuse admissions, including methamphetamine admissions, and admissions that could be diverted if there were local community services available. In response to these demands Wisconsin continues to develop local crisis stabilization and hospital diversion alternatives for all age groups. Over the next 2-3 years there will be at least another 8-12 counties certified to provide higher level crisis intervention services that are supported by Medical Assistance and private insurance. The new Comprehensive Community Services (CCS) benefit will provide much needed support for individuals who fall between traditional out-patient clinic services and more intensive services. These programs and others will help to strengthen the community’s ability to respond to individuals who may have otherwise required hospitalization or a shortened length of inpatient stay.

State Mental Health Institutes

Both Mendota and Winnebago Mental Health Institutes provide excellent assessment and treatment services and programs for children and adolescents. (Treatment for adolescent girls is only available at Winnebago, however.) The institutes back-up the local mental health system when a child requires a comprehensive mental health assessment that can not be provided for in the community. The institutes also provide placements for children who are at risk of suicide, are at risk of other dangerous behaviors toward their self or others, or need a very structured longer-term treatment environment.

The two institutes offer on-staff physicians, nurses, occupational therapists, social workers and aids. This is similar to staffing in a community inpatient unit, but provides a more secure, highly supervised and monitored locked setting. The institutes are used for youth who are experiencing acute psychiatric symptoms and need a safe environment for stabilization, medication evaluation, and/or are a danger to themselves or others. Children and youth can be admitted voluntarily or by court order.

The Wisconsin Managed Care Context

Wisconsin has a strong track record in the design and management of Medicaid managed care programs, innovative demonstrations, and long-term care waiver programs. Health and long-term care represent over 80 percent of the Department’s Medicaid budget. In Wisconsin, persons on
Supplemental Security Income (SSI) automatically qualify for Medicaid services. Relevant examples of Wisconsin programs include those summarized below.

**Mental Health Managed Care Programs for Children**

Wisconsin has two Medicaid managed care programs for mental health services for children with SED and who are at risk for out-of-home placement: Children Come First (Dane County) and Wraparound Milwaukee. The programs are financed in part through the Wisconsin Medicaid Program. The Division of Health Access and Accountability (DHAA) monitors the Medicaid contracts for the programs.

The mission of the Children Come First Program is to prevent or minimize the institutionalization of youth diagnosed with a severe emotional disturbance. The Wisconsin Medicaid program provides Dane County with a capitated monthly rate to serve youth who are diverted from psychiatric hospitals. Dane County pools this with other county funding to divert youth from Child Care Institutions (CCI's) and Corrections. The county chooses to provide those services in two broad groups: one through the Community Partnerships organization and the other through a separate unit in the Department called: "Achieving Reintegration Through Teamwork" (ARTT). The ARTT Unit works primarily with youth who have been in treatment institutions and transitions them back to the community, while the Community Partnerships program works primarily to divert youth who are at immediate risk of institutionalization. Community Partnerships and ARTT are co-located in a community setting.

Wraparound Milwaukee is a unique type of managed care entity. It was initiated in 1995 with a six year, $15 million grant from the Center for Mental Health Services. Its primary focus is to serve children and adolescents who have serious emotional disorders and who are identified by the Child Welfare or Juvenile Justice System as being at immediate risk of residential, correctional placement or psychiatric hospitalization. Wraparound Milwaukee serves an average enrollment of 615 youth and their families. In 2008, the program served a total of 1,236 severely emotionally disturbed children and youth.

A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the Wisconsin Medicaid Program provide funding for the system. Funds from the 4 systems and Departments are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Part of the Milwaukee County's Behavioral Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds acting as a public care management entity.

Wraparound Milwaukee contracts with nine community agencies that manage approximately 72 care coordinators. Care coordinators facilitate the delivery of services and other supports to families using a strength-based, highly individualized Wraparound approach. Wraparound Milwaukee has also organized an extensive provider network of 204 agency and individual providers that can offer an array of over 80 services to families. A Wraparound Milwaukee operated Mobile Urgent Treatment Team ensures families have access to crisis intervention services.

Wraparound Milwaukee involves families at all levels of the system and aggressively monitors quality and outcomes. It operates from a value base that emphasizes: building on strengths to meet needs; a one family-one plan of care; cost-effective community-based alternatives to residential treatment placements; juvenile correctional placement as appropriate; psychiatric
hospitalization; increased parent choice and family independence; and care for children within the
context of their family and community.

In October of 2007, Wraparound Milwaukee began its expanded program serving youth with
serious emotional and mental health needs that neither are non-court-involved nor referred
through Child Welfare or Juvenile Justice. The focus of the additional 200 youth to be served
will come from Milwaukee Public Schools (MPS), the Family Intervention & Support Program
(FISS), those referred from the Mobile Urgent Treatment Team (MUTT) and other areas. All
enrollments in the expanded Wraparound program will be on a voluntary basis. Families must be
Medicaid or BadgerCare eligible and youth must still meet the Medicaid definition of having a
serious emotional disturbance (SED).

Wraparound Milwaukee has a Quality Assurance/Quality Improvement unit responsible for
reviewing and evaluating the quality of the delivery of services to children with serious emotional
and mental health needs and their families and instituting measures to improve quality as needed.
Its primary functions include: creating, implementing and tracking family satisfaction – both at
the Care Coordination and Provider level; partnering with families and other system stakeholders
at the decision making level of policy and program development to assure that strength-based,
culturally sensitive care is being provided; creating and reviewing/revising ongoing program
policies and procedures; auditing at the Care Coordination and Provider level; monitoring
tracking and reporting on the established performance indicators identified for our affiliated Care
Coordination agencies; resolving consumer complaints/grievances; monitoring the requirements
set forth in our Medicaid contract with the State of Wisconsin; and engaging in monthly service
utilization review processes ensuring program and fiscal responsiveness.

Healthcare Programs

*The Medicaid Health Maintenance Organizations (HMO) Program*

The HMO Program was initiated in 1984 to manage Medicaid benefits to recipients of Aid to
Families with Dependent Children statewide. The HMO Program contracts with 14 HMOs
serving 66 of Wisconsin’s 72 counties.

*BadgerCare*

BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or
below 185 percent of the federal poverty level through a Medical expansion under Titles XIX and
XXI. The program goal is to fill the gap between Medicaid and private insurance without
supplanting private insurance. BadgerCare benefits are identical to the benefits and services
covered by Wisconsin Medicaid, and recipients’ health care is administered through the same
delivery system. No asset test is required.

According to the 2007 Wisconsin Family Health Survey, it is estimated that approximately
64,000 children (five percent of the 1,293,000 children in the state) were uninsured for part or all
of 2007. Eight percent of children living in poor households (10,000) and 10 percent of children
living in near-poor households (23,000) had no health insurance during part or all of 2007. This
contrasts with three percent of children living in non-poor households (29,000) who had no
insurance during part or all of 2007.
BadgerCare Plus Core Plan

Wisconsin Medicaid began implementation of the BadgerCare Plus Program on April 1, 2009. 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.

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

BadgerCare Plus Benchmark Benefit 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 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.

Medicaid Purchase Plan

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.
Under MAPP, participants:

- receive the same health benefits offered through the Medicaid (MA) Program;
- may earn more income, than another group of Medicaid (MA) recipients, without the risk of losing health care coverage; and
- are allowed increased personal and financial independence through saving opportunities, known as Independence Accounts.

**Katie Beckett Program**

The Katie Beckett Program (DBP) allows certain children with long term disabilities or complex medical needs, living at home with their families, to obtain a Wisconsin Medicaid card. As of March of 2009, there are 575 out of a total of 4,480 children (about 13 percent) who are eligible for Medicaid through the Katie Beckett Program and have an SED level of care. Some children are eligible for more than one program by which they could access Medicaid benefits (e.g., a child might be eligible for both KBP and SSI at the same time), therefore, not all eligible children will enroll in the Katie Beckett program.

Children who are not eligible for other Medicaid programs because their parents’ income or assets are too high may be eligible for Medicaid through the Katie Beckett Program, if the child:

1. is under 19 years of age and determined to be disabled by standards in the Social Security Act;
2. requires a level of care at home that is typically provided in a hospital or nursing facility;
3. can be provided safe and appropriate care in the family home;
4. as an individual, does not have income or assets in his or her name in excess of the current standards for a child living in an institution; and
5. does not incur a cost at home to the Medicaid Program that exceeds the cost Medicaid would pay if the child were in an institution.

If the Katie Beckett Program application is approved, the child will receive a Medicaid card which can be used to pay for services and equipment allowed under the Wisconsin Medicaid Program.

**Health Check Program**

Health Check is a federally-mandated Medicaid program known nationally as Early and Periodic Screening, Diagnosis, and Treatment. Health Check consists of a comprehensive health screening of Medicaid recipients under the age of 21. The screening includes, but is not limited to the following:

- a review of the recipient’s health history;
- an assessment of growth and development;
- identification of potential physical or developmental problems;
- preventive health education; and
- referral assistance to providers.

The Health Check screen will determine if a child is eligible for services that are not otherwise in Wisconsin’s MA State Plan but are allowable under MA federal regulation. Services provided by
Health Check as appropriate include case management, outpatient therapy, inpatient services, day treatment, and intensive in-home services. Other physical, mental, or dental health problems discovered in the Health Check examination are also referred for further diagnosis and treatment. The use of the Health Check system to screen for Medicaid-eligible children who have SED appears to be underutilized, and this underutilization creates an opportunity for increased public and provider awareness and education.

**Certified Mental Health Programs**

The following table gives an overview of the current certified mental health programs in the state.

**Table 1:**

<table>
<thead>
<tr>
<th>Number of Programs</th>
<th>Program Area</th>
<th>Regulated by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Inpatient</td>
<td>DHS 61.70 – 61.72</td>
</tr>
<tr>
<td>19</td>
<td>Emergency Service 2</td>
<td>DHS 34 Sub II</td>
</tr>
<tr>
<td>44</td>
<td>Emergency Service 3</td>
<td>DHS 34 Sub III</td>
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<td>23</td>
<td>Day Treatment</td>
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<td>15</td>
<td>Adolescent Inpatient</td>
<td>DHS 61.79</td>
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<td>Day Treatment Services for Children 1</td>
<td>DHS 40 Level I</td>
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<td>10</td>
<td>Day Treatment Services for Children 2</td>
<td>DHS 40 Level II</td>
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<td>Day Treatment Services for Children 3</td>
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<td>818</td>
<td>Outpatient</td>
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<tr>
<td>78</td>
<td>Community Support Programs (CSP)</td>
<td>DHS 63</td>
</tr>
<tr>
<td>26</td>
<td>Comprehensive Community Services</td>
<td>DHS 36</td>
</tr>
</tbody>
</table>

**Employment and Educational Services**

The five major areas in which Wisconsin addresses children with mental health needs and behavioral disabilities in schools include: 1) the Federal Office for Civil Rights 504 Plans; 2) compliance with the Individuals with Disabilities Education Act (IDEA); 3) Individual Educational Plans (IEPs); 4) pupil services; and 5) services for children with an emotional behavioral disability.

**504 Plans**

Section 504 is a federal law designed to protect the rights of individuals with disabilities in programs and activities that receive federal funds from the U.S. Department of Education (ED). The Section 504 regulation requires a school district to provide a "free appropriate public education" (FAPE) to each qualified student with a disability who is in the school district's jurisdiction, regardless of the nature or severity of the disability. FAPE consists of the provision of regular or special education and related aids and services designed to meet the student's individual needs.

Section 504 requires recipients to provide to students with disabilities appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met. An appropriate education for a student with a disability under the Section 504 regulations could consist of education in regular classrooms, education in regular classes with supplementary services, and/or special education and related services.
Section 504 Plans are developed where appropriate for Wisconsin students with mental health and behavioral disabilities and the state follows federal guidelines in the implementation of those plans.

**IDEA**

Schools in Wisconsin adhere to the requirements under the Federal Individuals with Disabilities Education Act (IDEA). The services provided under the Act in all Wisconsin districts for children with severe emotional disturbance include: counseling, mentoring, referring to services, and other student assistance practices and programs. Programs include assistance provided by qualified school-based mental health services providers and the training of teachers by school-based mental health services providers in appropriate identification and intervention techniques for students at risk of violent behavior and illegal use of drugs. Expanded and improved school-based mental health services provided by some districts include: illegal drug use and violence prevention; including early identification of violence and illegal drug use, assessment, and direct or group counseling services provided to students, parents, families, and school personnel by qualified school-based mental health service providers. Also, services to support Individual Education Plans (IEPs) are provided.

**IEPs**

Individual Education Plans (IEPs) are a written statement for each child (student) with a disability that is developed, reviewed, and revised in accordance with the following requirements:

1) A statement of the child's present levels of academic achievement and functional performance, including--
   - how the child's disability affects the child's involvement and progress in the general education curriculum;
   - for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities; and
   - for children with disabilities who take alternate assessments aligned to alternate achievement standards, a description of benchmarks or short-term objectives.

2) A statement of measurable annual goals, including academic and functional goals, designed to--
   - meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum; and
   - meet each of the child's other educational needs that result from the child's disability.

3) A description of how the child's progress toward meeting the annual goals will be measured and when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided.

4) A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child.
In Wisconsin, a child who has difficulty learning and functioning and has been identified as a special needs student is appropriate for an IEP. Children struggling in school may qualify for support services, allowing them to be taught in a special way, for reasons such as:

- Learning disabilities
- Attention deficit hyperactivity disorder (ADHD)
- Emotional disorders
- Mental retardation
- Autism
- Hearing impairment
- Visual impairment
- Speech or language impairment
- Developmental delay

In most cases, the services and goals outlined in an IEP can be provided in a standard school environment. This can be done in the regular classroom or in a special resource room in the regular school. The resource room can serve a group of children with similar needs who are brought together for help.

However, children who need intense intervention may be taught in a special school environment. These classes have fewer students per teacher, allowing for more individualized attention. In addition, the teacher usually has specific training in helping children with special educational needs. The children spend most of their day in a special classroom and join the regular classes for nonacademic activities (like music and gym) or in academic activities in which they do not need extra help.

Because the goal of IDEA is to ensure that each child is educated in the least restrictive environment possible, effort is made to help kids stay in a regular classroom. However, when needs are best met in a special class, then kids might be placed in one.

In Wisconsin, for youth in the school system ready for transition services, the primary function of each adolescent’s Individualized Education Plan (IEP) is to provide assistance, supports, and rehabilitation services to meet their educational and vocational goals. Ideally, these services should be implemented through integrated and wraparound processes and the IEP should reflect and support these processes. Some training on how to provide needed supportive education services, including transition to employment services, is available to schools through the Department of Public Instruction (DPI) and their contract with the Cooperative Education Service Agencies (CESAs). Other training opportunities for school staff include: the annual Children Come First and Crisis Conferences, the Wisconsin Statewide Transition Initiative, and Transition and Rehabilitation Conferences. Experienced practitioners from within and outside of Wisconsin, who are strongly focused on the needs of young adults, are trainers at these events.

The Division of Vocational Rehabilitation (DVR) has over 200 counselors who are assigned as liaisons to over 400 school districts in Wisconsin. DVR and DPI developed a new interagency agreement for the delivery of vocational services to youth in transition from high school to adult services and employment. DVR and DPI, in cooperation with CESAs, are conducting training on the agreement and new Individuals with Disabilities Education Act (IDEA) regulatory provisions around the state. For the first time the Department of Health Services is a partner in this inter-agency agreement.
Pupil Services

Collaborative pupil services refer to how pupil services professionals work together to meet the needs of all students. Many Wisconsin school districts have moved from the traditional approach of pupil services programming with professionals from each discipline working in isolation to pupil services staff working as a team and in conjunction with teachers, administrators, parents/families, and community partners. This collaborative model increases the effectiveness of the services provided by utilizing available resources most efficiently.

The goals of a collaborative pupil services system are to:

- Increase academic achievement;
- Help students to become confident, caring, and contributing citizens;
- Provide students with comprehensive, coordinated, integrated, and customized supports that are accessible, timely, and strength-based;
- Involve families, fellow students, educators, and community members as integral partners in the provision of a supportive, respectful learning environment; and
- Integrate the human and financial resources of public and private agencies to create caring communities at each school.*


Pupil services professionals use a variety of strategies that fall into one (or more) of the following categories to help young people reach their maximum potential. They include:

- Assessment, screening, and evaluation;
- Individual and small group counseling;
- Home-school collaboration;
- Classroom instruction;
- Collaboration and partnerships with community-based systems;
- Services for staff;
- Program and resource development, management, and evaluation; and
- System change and policy.

Assessment, Screening, and Evaluation

Includes the formal and informal methods used by pupil services professionals to determine levels of student achievement or functioning in academic, social-emotional, behavioral, physical/health, and career areas. The assessment or screening of students may occur individually or in groups. Common examples include:

- Evaluate a student for services or accommodations as a member of an IEP or 504 Team;
- Administering a survey to all or selected groups of students;
- Determining student response to interventions designed to improve functioning;
- Screening a student in crisis, e.g., suicide risk; and
- Participating in team meetings for individual student evaluations: IEP, 504, consultation teams, etc.

Individual and Small Group Student Services

Include the wide range of services (other than assessment, evaluation, and screening) provided to students individually or in small group. Common examples include:
• Individual and small group counseling and support;
• Related services as part of a student's IEP;
• Transitional services for students moving from one grade or school to another; and
• Case management.

Home-School Collaboration
Includes ways that pupil services professionals connect with the families of students. Most, but not all, of these efforts involve providing services to individual parents and families, but some activities engage families as partners in improving the school-community. Examples include:
• Sharing referral information and resources;
• Providing parent education and support activities;
• Conducting home visits; and
• Career planning with students and parents.

Classroom Instruction
Includes a variety of developmental topics presented to students to support their academic, personal/social, and career development. Examples of topics include:
• Developmental guidance;
• Human growth and development;
• Physical health;
• Prevention of violence, e.g., child abuse, dating violence, bullying;
• Mental health and illness; and
• Suicide prevention.

Collaboration and Partnerships with Community-based Systems
Includes the ways that pupil services professionals network with community-base systems, such as human services, law enforcement, juvenile justice, public health and higher education. Examples include:
• Serving as a community liaison;
• Providing community outreach;
• Managing transitions to and from treatment, foster care, and residential settings;
• Serving on collaborative services teams to provide wrap-around services; and
• Developing referral systems with community-based mental health agencies.

Services for Staff
Services for staff are those services specifically intended for educator colleagues within the school/district. The primary examples are:
• In-service training and other professional development;
• Individual and small group training;
• Employee assistance and wellness programs; and
• Consultation with staff regarding students' academic, health, and social-behavioral challenges.

Program and Resource Development, Management, and Evaluation
Include the programs and resources that pupil services professionals create, manage, and evaluate. Programs and resources may target all students or a select group of students within a school. Examples include:
• Coordinating school-wide, standardized evaluations, e.g., Wisconsin Knowledge and Concept Examination (WKCE), Measure of Academic Progress (MAP), etc.; grant-writing and management;
• Curriculum writing and revision;
• Evaluating and improving school climate; and
• Program audits to help the school district meet expectations for student achievement and success.

**Systems Change and Policy**
Systems change and policy covers the efforts of pupil services professionals to implement systemic changes and improvements in the school/district. Examples include:
• Policy development and revision;
• Advocacy for system change;
• And use of evaluation results to guide recommended changes in policies and programs.

**Services for Children with an Emotional Behavioral Disability in Wisconsin Schools**
In Wisconsin school systems, the term "emotional disturbance" (ED) was changed to "emotional behavioral disability" (EBD), effective July 1, 2001. In order for a student to be identified as EBD there are four key concepts to be addressed: 1) the student exhibits social, emotional or behavioral functioning that so departs from generally accepted, age appropriate ethnic or cultural norms that it adversely affects a child's academic progress, social relationships, personal adjustment, classroom adjustment, self-care or vocational skills; 2) the behaviors are severe, chronic, and frequent, occur at school and at least one other setting, and the student exhibits at least one of eight characteristics or patterns of behavior indicative of EBD; 3) the IEP team used a variety of sources of information including observations and has reviewed prior, documented interventions; and, 4) the IEP team did not identify or refuse to identify a student as EBD solely on the basis of another disability, social maladjustment, adjudicated delinquency, dropout, chemical dependency, cultural deprivation, familial instability, suspected child abuse, socioeconomic circumstance, or medical or psychiatric diagnostic statements.

**Programming**
A continuum of educational placements is necessary to appropriately serve students who are EBD. Some students who are EBD are appropriately served in regular education classrooms with supplementary aids and services, while others may require self-contained or pullout programming for all or part of their school day. There is an increased emphasis on developing positive behavior intervention plans (BIPs) as part of the IEP when the student's behavior impacts his/her learning or that of others. This requirement clearly applies to all students who are EBD. The emphasis is on positive interventions and strategies to address the behaviors of concern, and the plan should be based on the most recent evaluation results including information from a functional behavioral assessment (FBA).

Based on the December 1, 2004 child count, there were 16,431 students (ages 3-21) identified as having a primary disability of EBD. This was a slight increase from the previous year. The prevalence rate (unduplicated count divided by total enrollment in public and private schools) of EBD in Wisconsin is 1.6 percent.

**Transitional Services**
For youth in the school system ready for transition services, the primary function of each adolescent’s Individualized Education Plan (IEP) is to provide assistance, supports, and
rehabilitation services to meet their educational and vocational goals. Ideally, these services should be implemented through integrated and wraparound processes and the IEP should reflect and support these processes. Some training on how to provide needed supportive education services, including transition to employment services, is available to schools through the Department of Public Instruction (DPI) and their contract with the Cooperative Education Service Agencies (CESAs). Other training opportunities for school staff include: the annual Children Come First and Crisis Conferences, the Wisconsin Statewide Transition Initiative, and Transition and Rehabilitation Conferences. Experienced practitioners from within and outside of Wisconsin who are strongly focused on the needs of young adults, are trainers at these events.

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Barriers to better employment and educational experiences include the lack of advanced planning, insufficient supportive services targeted for youth/adolescents, lack of employment opportunities both during and post high school, funding, accommodation issues, and stigma. The complexities of work eligibility, fragmentation of services and information around work, earned income, and access to critical health care supports have traditionally made employment outcomes poor. The most common source of initial supported employment funding comes from DVR funding. DVR is currently serving individuals with a waiting list of less than 100 individuals statewide. DVR is now instituting Employment Supports Planning to focus on all possible sources of support so that services are sustainable for each individual referred.

Families and consumers have requested increased access to benefit specialist services and the Benefits Planning, Assistance, and Outreach Program, a five-year demonstration project funded by the Social Security Administration, has accomplished this. They are available to every county and for people with disabilities ages 16-64. There are also many fee-for-service benefit counseling services, which can be paid for privately or via community and vocational agency funding, such as DVR funding. These specialists also address housing, food stamps, and health insurance in addition to Supplemental Security Income (SSI) and Social Security Disability Insurance. The Medicaid Purchase Plan and Health and Employment Counseling (HEC) are relatively new programs that make employment more attractive to older teens because these programs provide for health care coverage to those people with disabilities who work, and in the case of HEC, those who are looking for employment.

**Housing Services**

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

*For More Information on Housing See Section "Available Services--Adults."

Issues Related to Affordability of Housing for Low-Income Women and Children in Wisconsin

Although there are supportive housing programs in Wisconsin, there is a paucity in low-income housing stock and subsidized housing vouchers. This makes it difficult for low-income families (many of which have adults and children suffering from mental health problems) to secure and keep housing.

- It is very difficult to build housing in Wisconsin that a low-income family can afford without somebody heavily subsidizing either the developer or the family who ends up buying or renting the unit. The sum of the costs of land, construction, financing and various other fees involved in creating a unit of housing do not match up with what low-wage workers make in the current labor market. The ability of low-income people to pay for their housing needs to be enhanced by expanding income support programs like the Earned Income Tax Credit or housing subsidies like the federal Section 8 voucher program; and by targeting greater federal resources toward the development of housing that is affordable to families at the lowest end of the income distribution.

- The Section 8 program's goal was to allow low-income people to rent in the open market and provide them with opportunities to be integrated into the community. Waiting lists are common and vary from weeks to years in length. The major problem with waiting lists is that tenants are often purged from the list when the housing authority loses contact with them. This happens frequently because tenants who need housing assistance move often. There has also been major landlord opposition to the Section 8 program because in the past a "lease in perpetuity" was required. Although this is no longer the case, some landlords are not aware of this change. Also, some landlords believe that if they accept one Section 8 tenant, they must take all others that apply. This is not true, but adds to the stigma of the program. Additionally, landlords object to having to collect rent directly from tenants as a large proportion of the tenants are below the poverty line and are therefore "uncollectible," meaning their wages and assets cannot be garnished. Finally, many landlords continue to object to the program because they do not want to sign the HUD lease or be subject to rules that HUD may change during the lease period. Some landlords are also hesitant to let housing authority building inspectors in to inspect the unit, and many do not want to make the repairs that are required in order to rent to a Section 8 tenant.

- Milwaukee County has the only emergency shelter in the state specifically targeted to teenagers and children. La Causa Incorporated runs the facility. La Causa is one of the largest bilingual, multicultural agencies in Milwaukee. La Causa provides children, youth and families with services to nurture healthy family life and enhance community stability. Their staff members provide a broad range of family-centered services: from early education and care to elementary and middle school education in a Charter School setting; from foster care recruitment to mental health treatment services to parenting
classes and support groups; and from ensuring children’s most basic needs are met to providing shelter and resources for families in crisis.

**Substance Abuse Services**

DHS continues to seek out the latest research on treatment, prevention, and recovery, and to disseminate information to the substance abuse field for improvement in treatment outcomes. DHS has partnered with the Prairie Lands Addiction Technology Transfer Center. This partnership brings national experts to Wisconsin providers in teleconference training by researching and incorporating the latest science into its service delivery system. Wisconsin is working hard to support effective prevention and treatment programs by improving the use of evidence-based practices and putting resources behind them. Wisconsin has had an Access to Recovery grant program in Milwaukee. This voucher program provides substance abuse treatment funding for use with evidence-based treatment and supportive services. This grant has brought $22 million federal dollars for services and facilitated a comprehensive substance abuse system which includes: a voucher based treatment provider network; recovery support; and faith based provider services. The Department of Health Services continues to seek out additional federal and other resources to provide additional services.

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

DMHSAS is focusing efforts to provide increased education and outreach to providers on best-practice integrated treatment services. The annual DMHSAS-sponsored conference on integrated services was held in fall 2008. All of the DMHSAS conferences since 2005 have had a track for professional development in integrated services. Many county agencies are encouraging their mental health staff to obtain the substance abuse counselor specialty for community services and the Department of Regulation and Licensing and DMHSAS are working together to ensure that the training for the specialty is accessible and flexible.

The CCS benefit was designed to provide integrated mental health and substance abuse services. County programs are just beginning to focus on developing their substance abuse services array.

**Data on Youth Substance Abuse**

Wisconsin recently received a Strategic Prevention Framework-State Incentive (SPF-SIG) Grant to implement and epidemiological study which will provide data on which to base system of care development and evidence-based practices for substance abuse treatment.* Wisconsin’s 2008 “Epidemiological Profile Report” provides indicators on the consumption of alcohol and other drugs and related consequences for adults and youth.**

*For information on "County-Based Dual Diagnosis Services" See Section "Available Services--Adults."
Medical and Dental Services

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 people would be unable to receive essential services or would receive uncompensated care.

Dental Services

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 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 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 who on 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.

Interagency Agreement Regarding Transition Services and Post-School Employment Goals

The Department of Workforce Development (DWD)- Division of Vocational Rehabilitation (DVR), the Department of Public Instruction (DPI)- Division for Learning Support Equity and Advocacy (DLSEA), and the Department of Health Services (DHS)-Division of Long-Term Care (DLTCT) and Division of Mental Health and Substance Abuse Services (DMHSAS) are clarifying their relationship in order to establish a common understanding regarding their roles, policies, and procedures related to providing transition services and supports for students with disabilities entering employment.

The purpose of the Department of Public Instruction (DPI), Department of Health Services (DHS) and Division of Vocational Rehabilitation (DVR) Interagency Agreement is to fulfill interagency agreement mandates found in the Individuals with Disabilities Education Act and the Rehabilitation Act and to coordinate services for individuals transitioning from education to employment.

The agreement between DPI, DVR, and DHS has six overall goals/objectives:

1. to comply with federal legal mandates under the Rehabilitation Act of 1998 and The Individuals with Disabilities Education Act of 2004 (IDEA),
2. to provide practical guidance to school district special and regular education teachers, nurses, psychologists, administrators, and guidance counselors regarding transition services and supports,
3. to provide practical guidance to vocational rehabilitation counselors regarding transition services and supports,
4. to provide practical guidance to counties, Care Management Organizations (CMOs) and Aging Disability Resource Centers (ADRCs) regarding students with disabilities who are transitioning to the adult long term care system and the mental health/substance abuse system,
5. to provide information on transition services to students and their parents so they will be able to participate fully in transition planning, and
6. to provide clarification of roles and responsibilities of staff within school districts, DVR and for entities contracting with DHS (counties and CMOs) regarding students with disabilities, including mental health and substance abuse (MH/SA) issues, who have identified long term needs in employment and independent living.

Stakeholders from DPI, DVR and DHS come together to participate on the Mental Health Transition Advisory Council. The Council has advocated for the inclusion of transition as a topic at conferences across the state, and has developed and provided hundreds of "Transition Resource Guides" and "Do It Yourself Case Management" handouts at conferences and meetings. Council members have also networked with other members as part of providing informed consultations on consumers and their families who are faced with imminent transition into the adult mental health system. The council is also developing additional resource material for consumers and their families, as well as mental health providers. Additionally, the Council has collaborated with the Madison Metropolitan School District to distribute their transition guide, utilizing it as a model for other districts.

The "Transition Resource Guide" (for Adolescents with Mental and/or Emotional Disorders and Their Families) includes information on:

- Statewide Resource Agencies and Organizations organized by region
- Medicaid Benefit Programs
- Employment Counseling Services
- Advocacy Agencies/Private Consultants
- Minority Services
- Helpful Websites
- Book References
- Contact information for CESA Transition Coordinators
- Benefit Counseling Providers
- Record Keeping Suggestions

The "Do-It-Yourself Case Management and Advocacy" handout includes information on:

- Housing
- School, including information about GEDs and HSEDs
- Emergency Housing
- Social Security
- Mental Health Treatment/Medication
- Employment/DVR
- A list of steps to take to negotiate transition from the children's to the adult mental health systems
- Record Keeping Suggestion
Case Management Services

Case management services are provided to children served by the child welfare system. In general terms, this means a case manager coordinates, provides, or advocates for intensive community services to meet a child’s physical, psychological and developmental needs. Case managers have an established relationship with the child and the family and coordinate services across multiple agencies.

Targeted Case Management

Medicaid targeted or intensive case managers generally have smaller caseloads than case managers, usually an average of 8-12 families. After eligibility is determined, case managers make initial contact with the child and family to determine the family’s strengths. Under Medicaid, Wisconsin provides targeted case management, inpatient hospitalization, and outpatient clinic and other services for individuals under the age of 21. It also provides medically indicated services such as medication checks, assessment, and diagnosis if a provider can be found that accepts Medicaid.

The population served through targeted case management includes families whose children are at risk of serious physical, mental, or emotional dysfunction. This concept, referred to as Family Care management, expands coverage to families that include one or more children who have special health care needs, are at risk of maltreatment, or are involved in the juvenile justice system, as well as families where the mother requires prenatal care coordination services.

Medicaid has paid for targeted case management services since 1987. While counties, independent living centers and tribes are the only agencies that may receive reimbursement for these case management activities, they may sub-contract with other entities that provide case management services to children and their families.

Services for persons with co-occurring (substance abuse/mental health) disorders and other activities leading to reduction of hospitalization.

Tribal State Collaborative for Positive Change

The Tribal State Collaborative for Positive Change (TSCPC) was established in January of 2007 in order to provide a forum for the Wisconsin tribal mental health professionals, substance abuse coordinators and DHS personnel. The TSCPC is dedicated to improving the quality of behavioral health programming within tribal communities. In Federal Fiscal Year 2007, the TSCPC was awarded a $100,000 Mental Health Block Grant allocation for the purpose of initiating systems change within tribal behavioral health programs for the treatment of co-occurring disorders. The Sokaogon Chippewa Community is the fiscal agent for the TSCPC Systems Change Project.

During FFY 2008, the TSCPC experienced ongoing challenges in initiating systems change processes within their respective communities. As the TSCPC was a relatively newly formed workgroup, they experienced a core challenge of clearly defining roles responsibilities between tribal workgroup members, DHS representatives, the fiscal agent and the project coordinator hired by the Sokaogon Chippewa Community. In September 2008, due to under spending, the DMHSAS reduced the FFY 2008 contract by $30,000. The Systems Change Project was again funded for FFY 2009 with an allocation of $100,000 of MHBG funds. It has taken the
workgroup a considerable amount of time to organize the project processes, as this is the Department’s first attempt to develop an inter-tribal project of this nature.

In 2008 the TSCPC conducted a specific needs assessment utilizing the COMPASS assessment tool. Eight of the eleven tribes completed the assessment. Five tribal representatives expressed a need for technical assistance in interpreting the results and initiating action steps related to prioritization of community goals for systems change. An educational training to help define co-occurring disorders, general awareness of challenges in creating system change, cultural competence and a strategic planning training occurred. More intense follow-up was also provided.

The TSCPC advisory group plans to continue working on a co-occurring systems change process and has invited strategic planning consultants to help facilitate the process within their respective communities.

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

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.

*For more information on CLTS Waivers see Children's Section: "New Developments and Issues."*
Wisconsin

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 2: Mental Health System Data Epidemiology

Directions: An estimate of the incidence and prevalence in the state of serious mental illness among adults and serious emotional disturbance among children.

Estimate of Prevalence

This section includes the definition used by the DHS for children with SED and the methodology used to determine the number of children and families needing services. The following definition used by Wisconsin is nearly identical to the one used by the Center for Mental Health Services. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must be in evidence by (1), (2) (3) and (4).

(1) The disability must have persisted for 6 months and be expected to persist for a year or longer.

(2) A condition of SED as defined by:

A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic categories appropriate for children and adolescents.

(3) Functional symptoms and impairments consisting of either A. or B.

A. Symptoms - the individual must have one of the following:

1. Psychotic symptoms - serious mental illness, e.g., schizophrenia characterized by defective or lost contact with reality, often with hallucinations or delusions.

2. Danger to self, others, and property as a result of emotional disturbance. The individual is self destructive, e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons, or significant damage to property.

B. Functional impairment in two of the following capacities (compared with expected developmental level):

---

1 Those DSM-IV categories are: substance related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, dissociative disorders, sexual and gender identity disorders, impulse-control disorders, adjustment disorders and personality disorders. Disorders usually first evident in infancy, childhood and adolescence including pervasive developmental disorders, attention deficit and disruptive behavior disorders, tic disorders, stereotypic movement disorder, feeding and eating disorders, separation anxiety disorder, selective mutism and reactive attachment disorder.
1. **Functioning in self-care** - Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

2. **Functioning in community** - Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment, and value systems, which results in potential involvement or involvement with the juvenile justice system.

3. **Functioning in social relationships** - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

4. **Functioning in the family** - Impairment in family function is manifested by a pattern of significantly disruptive behavior. It is exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations, which may result in removal from the family or its equivalent.

5. **Functioning at school/work**
   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, e.g., consistently failing grades, repeated truancy, expulsion, property damage, or violence toward other,
   b) Identified as having as emotional/behavioral disability (EBD) under chapter PI 11, Wis. Admin. Code, and Section 115.76 Wis. Stats., and
   c) Impairment at work is the inability to be consistently employed at a self-sustaining level, e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, along with hostile behavior on the job.

(4) The individual is receiving services from two or more of the following service systems, i.e.; mental health, social services, child protective services, juvenile justice, or special education.

**Prevalence Methodology**

While there are different methods for estimating prevalence of mental illnesses, Wisconsin bases its estimation methodology on that of the CMHS. The DMHSAS estimates that 106,149 children (11 percent) in Wisconsin between the ages of 5-17 will have an SED in 2010. The Census Bureau estimated Wisconsin’s poverty rate for children 17 and under in 2008 was 14.0 percent. Wisconsin’s rate is similar to the national poverty rate which puts it in the medium range for calculating mental health prevalence estimates as recommended by CMHS. Not all of these children will require specialized services nor do they need ISP level of service delivery. Some children can be served through outpatient services provided in the mental health and social services system.
Table 18
Wisconsin Prevalence Estimates of Children and Adolescents with SED

<table>
<thead>
<tr>
<th>By County, 2008 Population*</th>
<th>Children with an SED and &quot;Extreme Functional Impairment&quot;</th>
<th>Children with an SED and &quot;Substantial Functional Impairment&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>WI Poverty Rate = 14.0%**</td>
<td>Total Possible Range = 5% to 9%</td>
<td>Total Possible Range = 9% to 13%</td>
</tr>
<tr>
<td>Placed in Group with Medium Level of Poverty</td>
<td>WI Range = 6% to 8%</td>
<td>WI Range = 10% to 12%</td>
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<tr>
<td></td>
<td>Level of Functioning Score = 50</td>
<td>Level of Functioning Score = 60</td>
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<tr>
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<td># of Kids 5-17</td>
<td>Lower Limit @ 6%</td>
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<td>By County, 2008 Population*</td>
<td>Children with an SED and &quot;Extreme Functional Impairment&quot;</td>
<td>Children with an SED and &quot;Substantial Functional Impairment&quot;</td>
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<td>WI Poverty Rate = 14.0%**</td>
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<td>Placed in Group with Medium Level of Poverty</td>
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Wisconsin

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 2: Mental Health System Data Epidemiology
Quantitative Targets

Directions: Quantitative Targets to be achieved in the implementation of the system of care described under Criterion 1.

STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 1: To expand wraparound services to all counties.

Objective: To annually increase by two the number of counties with initiatives using the wraparound model in FFY 2010.

Population: Children with SED and their families.

Criterion: Comprehensive Community-Based System of Care.

Brief Name: Expand children’s wraparound programs.

Indicator: Percentage of counties with wraparound initiatives.

Measure: Numerator: Number of counties with wraparound initiatives in FFY 2010.
Denominator: Number of counties in Wisconsin.

Sources of Information: Department funding information for wraparound programs.

Special Issues and Strategy: The ultimate goal for Wisconsin is to expand integrated service programs using a wraparound approach in all counties statewide. Thus, to best reflect progress towards that goal, the indicator is stated as the percentage of all counties because it illustrates state coverage more effectively than the number of all counties. Not all county programs serving children are funded through the Mental Health Block Grant. The two largest counties sustain their children’s wraparound initiatives solely through Medicaid and county funds (see the performance indicator table for details). All of these county programs are included in this performance indicator.
Significance: The expansion of wraparound service programming for children is one of the top priorities of Wisconsin’s Mental Health Council and the DMHSAS.

The expansion of wraparound service programming for children addresses Goal 2, Recommendation 2.1 of the President's Freedom Commission on Mental Health:

Goal 2--Mental Health Care is Consumer and Family Driven.
Recommendation 2.1--Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 2: To facilitate the use of evidence-based practices for children.
(National Outcome Measure)

Objective: To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources.

Population: Children with SED and their families.

Criterion: Comprehensive Community-Based System of Care.

Brief Name: Evidence-based Practices Used.

Indicator: Number of evidence-based practices used for children in the state in FFY 2010.

Measure: Number of evidence-based practices used for children in the state in FFY 2010.

Sources of Information: Children’s mental health program information.

Special Issues and Strategy: None.

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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 3: To facilitate the use of evidence-based practices for children.
(National Outcome Measure)

Objective: To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources.

Population: Children with SED and their families.

Criterion: Comprehensive Community-Based System of Care.

Brief Name: Children Receiving Evidence-based Practices.

Indicator: Number of children receiving evidence-based practices in the state in FFY 2010.

Measure: Number of children receiving evidence-based practices in the state in FFY 2010.

Sources of Information: Children’s mental health program information.

Special Issues and Strategy: None.

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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 1

Goal 4: Improve client perception of care. (National Outcome Measure)

Objective: To increase the perception of care of parents/guardians annually by two percent annually.

Population: Children with SED.

Criterion: Comprehensive Community-Based Mental Health Service Systems.

Brief Name: Client perception of care.

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 2010. Denominator: The total number of parents or guardians responding to the youth survey in FFY 2010.

Source of Information: Mental Health Statistical Improvement Program's Youth Services Survey.

Special Issues and Strategy: 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.
CRITERION 2

CHILDREN’S PLAN QUANTITATIVE TARGETS 2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 2

Goal 1: To increase the number of children who have access to services in the public mental health system. (National Outcome Measure)

Objective: Increase by one percent annually the number of children served through the public mental health system.

Population: Children with SED and their families.

Criterion: Mental Health System Data Epidemiology.

Brief Name: Increase access to services.

Indicator: Number of children ages 0-17 receiving mental health services in FFY 2010.

Measure:

- **Numerator**: Number of children ages 0-17 receiving services through the public mental health system in FFY 2010 minus the number of children ages 0-17 receiving services through the public mental health system in FFY 2009.
- **Denominator**: Number of children ages 0-17 receiving services through the public mental health system in FFY 2009.

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

Special Issues And Strategies: 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.
CRITERION 3

CHILDREN’S PLAN QUANTITATIVE TARGETS 2010
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 3

Goal 1: Decrease the rate of readmission to psychiatric hospitals within 30 days.
(National Outcome Measure)

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

Population: Children and their families.

Criterion: Children’s Services.

Brief Name: Decrease psychiatric hospital episodes within 30 days.

Indicator: The percentage of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days.

Measures: Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days. Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010.

Sources of Information: HSRS data.

Special Issues And Strategy: 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 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 3

Goal 2: Decrease the rate of readmission to psychiatric hospitals within 180 days. 
(National Outcome Measure)

Objective: Decrease the rate of readmission to psychiatric hospitals within 180 days by at least one percent annually.

Population: Children and their families.

Criterion: Children’s Services.

Brief Name: Decrease psychiatric hospital episodes within 180 days.

Indicator: The percentage of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days.

Measures: Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days. Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010.

Sources of Information: HSRS data.

Special Issues and Strategies: 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.
Goal 3: Increase school attendance.  
(National Outcome Measure)

Objective: To increase the percentage of children whose school attendance has improved since receiving services by three percent annually.

Population: Children with SED.

Criterion: Children’s Services.

Brief Name: Increase school attendance.

Indicator: The percentage of children with SED whose school attendance has increased in FFY 2010 since starting mental health services.

Measure: Numerator: Number of children 6-18 years old with SED whose school attendance has increased in FFY 2010 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 2010.

Sources of Information: Mental Health Statistical Improvement Program’s (MHSIP) youth satisfaction survey.

Special Issues and Strategy: 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 3

Goal 4: Decrease juvenile justice involvement for mental health consumers. (National Outcome Measure)

Objective: To decrease the percentage of youth mental health consumers who recidivate by three percent annually.

Population: Children with SED.

Criterion: Children’s Services.

Brief Name: Decrease juvenile justice involvement.

Indicator: The percentage of youth with SED with no arrest in FFY 2010 after being arrested in FFY 2009.

Measure: Numerator: Number of youth 6-18 years old with SED who were arrested again in FFY 2010 after being arrested in FFY 2009. Denominator: Number of youth 6-18 years old with SED who were arrested in FFY 2009.

Sources of Information: Mental Health Statistical Improvement Program’s (MHSIP) youth satisfaction survey.

Special Issues and Strategy: 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 3

Goal 5: Increase stability in housing. (National Outcome Measure)

Objective: To decrease the percentage of youth consumers in unstable housing by one percent annually.

Population: Children with SED.

Criterion: Children’s Services.

Brief Name: Increase stability in housing.


Measure: Numerator: Number of children 0-17 years old with SED in an unstable living situation in FFY 2010.
Denominator: Number of children 0-17 years old with SED receiving services through the public mental health system in FFY 2010 for whom living situation data has been reported.

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

Special Issues and Strategy: 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.
**STATE PLAN PERFORMANCE INDICATOR**

**FFY 2010**

**Criterion 3**

**Goal 6:** Increase social supports/social connectedness.  
(National Outcome Measure)

**Objective:**  
To increase the percentage of parents/guardians of youth mental health consumers with social supports by one percent annually.

**Population:**  
Children with SED.

**Criterion:**  
Children’s Services.

**Brief Name:**  
Increased social supports.

**Indicator:**  
The number of parents/guardians of children with SED who have social supports in their community in FFY 2010.

**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 2010.
- **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 2010.

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

**Special Issues and Strategy**  
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 4 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.
STATE PLAN PERFORMANCE INDICATOR
FFY 2010

Criterion 3

Goal 7: Improved level of functioning. (National Outcome Measure)

Objective: To increase the percentage of youth consumers with improved functioning by three percent annually.

Population: Children with SED.

Criterion: Children’s Services.

Brief Name: Improved level of functioning.

Indicator: The percentage of youth with SED whose parent/guardian report improved functioning as a result of their mental health services in FFY 2010.

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 2010. 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 2010.

Sources of Information: Mental Health Statistical Improvement Program’s (MHSIP) youth satisfaction survey.

Special Issues and Strategy: 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 different domains of his/her life.
CRITERION 4

CHILDREN’S PLAN QUANTITATIVE TARGETS 2010
Criterion 4

Goal 1: Improve access to tele-health consultation in rural areas.

Objective: Increase the number of certified tele-health systems in rural counties by three annually.

Population: Children with SED and their families.

Criterion 4: Targeted Services to Rural and Homeless Populations.

Brief Name: Implement tele-health.

Indicator: Increase the number of certified tele-health systems in rural counties by three annually for FFY 2010.

Measure: The number of rural counties with certified tele-health systems in place to serve children in FFY 2010.

Source of Information: Certification data from the state.

Special Issues and Strategy: 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 tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
CRITERION 5

CHILDREN’S PLAN QUANTITATIVE TARGETS 2010
STATE PLAN PERFORMANCE INDICATOR

FFY 2010

Criterion 5

Goal 1: Increase the number of counties with children’s service staff trained in organizing collaborative service delivery systems within the children’s wraparound programs.

Objective: Annually increase by two the number of counties with children’s service staff trained in organizing collaborative service delivery systems within the wraparound programs.

Population: Children with SED and their families.

Criterion: Management Systems.

Brief Name: System organization training.

Indicator: Number of counties with mental health and other children’s service agency staff trained in organizing wraparound programs annually in FFY 2010.

Measure: 

Numerator: Number of counties with mental health and other children’s service agency staff trained in organizing wraparound programs in FFY 2010.

Denominator: Number of counties in Wisconsin in FFY 2010.

Source(s) of Information: ISP/CST training visit reports.

Special Issues and Strategies: 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.
Wisconsin

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

- Social services;
- Educational services, including services provided under the Individuals with Disabilities Education Act;
- Juvenile justice services;
- Substance abuse services; and

Health and mental health services.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 3: Children's Services

Directions: Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under section 1911 for the fiscal year involved for any services under such system other than comprehensive mental health services. Examples of integrated services include:

- Social services;
- Educational services, including services provided under the Individuals with Disabilities Education Act;
- Substance abuse services; and
- Health and mental health services.

System of Integrated Services

Community Mental Health Services

Wisconsin has been a national leader in the development of services for persons with mental illness. In the children’s mental health field, Wraparound Milwaukee has pioneered the use of managed care techniques to serve the complex needs of youth with serious emotional disorders who may also be involved in the juvenile justice, child welfare, or substance abuse systems. Wisconsin has also been facilitating the use of the system of care principles recommended by the Center for Mental Health Services through its integrated services for children's programming initiatives. This initiative has been slowly expanded to cover over half of the county and tribal systems in Wisconsin, including all of the major population areas.

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 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.
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 new services are known as Comprehensive Community Services (CCS). The new rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to both children and adults, including elders, 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.

Health and Rehabilitation Services

The required array of rehabilitation services available to consumers within Comprehensive Community Services projects include vocational assessment; job development; vocational supportive counseling; social and recreational skill training; and daily living support. Referrals to primary care physicians are made when indicated and transportation is provided if needed. The CCS* benefit will continue expand rehabilitation services offered throughout Wisconsin.

*For More Detail on the CCS Benefit See Section "Available Services Children."

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 Services and Treatment 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.*
*For More Detail on CST See Section "Available Services--Children."

**Program of Assertive Community Treatment--Pilot to Address Adolescents**

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 multidisciplinary 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 too 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.

**Mental Health Managed Care Programs for Children**

Wisconsin has two Medicaid managed care programs for mental health services for children with SED and who are at risk for out-of-home placement: Children Come First (Dane County) and Wraparound Milwaukee. The programs are financed in part through the Wisconsin Medicaid Program. The Division of Health Access and Accountability (DHAA) monitors the Medicaid contracts for the programs.

The mission of the Children Come First Program is to prevent or minimize the institutionalization of youth diagnosed with a severe emotional disturbance. The Wisconsin Medicaid program provides Dane County with a capitated monthly rate to serve youth who are diverted from psychiatric hospitals. Dane County pools this with other county funding to divert youth from Child Care Institutions (CCI's) and Corrections. The county chooses to provide those services in two broad groups: one through the Community Partnerships organization and the other through a separate unit in the Department called: "Achieving Reintegration Through Teamwork" (ARTT). The ARTT Unit works primarily with youth who have been in treatment institutions and transitions them back to the community, while the Community Partnerships program works primarily to divert youth who are at immediate risk of institutionalization. Community Partnerships and ARTT are co-located in a community setting.
Wraparound Milwaukee is a unique type of managed care entity. It was initiated in 1995 with a six year, $15 million grant from the Center for Mental Health Services. Its primary focus is to serve children and adolescents who have serious emotional disorders and who are identified by the Child Welfare or Juvenile Justice System as being at immediate risk of residential or correctional placement or psychiatric hospitalization. Wraparound Milwaukee serves an average enrollment of 618 youth and their families. In 2008, the program served a total of 1,236 SED children and youth.*

*For More Detailed Information on Wraparound Milwaukee See Section "Available Services-Children."

**Case Management**

Case management services are provided to children served by the child welfare system. In general terms, this means a case manager coordinates, provides, or advocates for intensive community services to meet a child’s physical, psychological and developmental needs. Case managers have an established relationship with the child and the family and coordinate services across multiple agencies.

**Targeted Case Management**

Medicaid targeted or intensive case managers generally have smaller caseloads than case managers, usually an average of 8-12 families. After eligibility is determined, case managers make initial contact with the child and family to determine the family’s strengths. Under Medicaid, Wisconsin provides targeted case management, inpatient hospitalization, and outpatient clinic and other services for individuals under the age of 21. It also provides medically indicated services such as medication checks, assessment, and diagnosis if a provider can be found that accepts Medicaid.

The population served through targeted case management includes families whose children are at risk of serious physical, mental, or emotional dysfunction. This concept, referred to as Family Care management, expands coverage to families that include one or more children who have special health care needs, are at risk of maltreatment, or are involved in the juvenile justice system, as well as families where the mother requires prenatal care coordination services.

Medicaid has paid for targeted case management services since 1987. While counties, independent living centers and tribes are the only agencies that may receive reimbursement for these case management activities, they may sub-contract with other entities that provide case management services to children and their families.

**Social Services**

**Child Welfare Program Enhancement Plan**

In August of 2003, Wisconsin’s child welfare program underwent a Child and Family Services Review conducted by the federal Administration for Children and Families. As a result of this review, Wisconsin submitted a Child Welfare Program Enhancement Plan (PEP). The action steps Wisconsin will take to improve child safety, permanency and well being are outlined in the Matrix portion of the PEP. The PEP Matrix includes 20 specific action steps to improve child
welfare program outcomes and systemic factors. One of these action steps requires Wisconsin to work with children’s mental health experts and county and tribal child welfare agencies to develop a statewide policy on the screening and assessment of the mental health needs of children who have been abused or neglected. Another seeks to provide support to workers through training and technical assistance to identify mental health issues of children and parents and address them in the ongoing services case plan.

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.

The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, but primarily on trauma. The new pilot will target five counties in the northeast region of the state.

**Educational services, including services provided under the Individuals with Disabilities Education Act (IDEA)**

Schools in Wisconsin adhere to the requirements under the Federal Individuals with Disabilities Education Act (IDEA). The services provided under the Act in all Wisconsin districts for children with severe emotional disturbance include: counseling, mentoring, referral services, and other student assistance practices and programs, including assistance provided by qualified school-based mental health services providers and the training of teachers by school-based mental health services providers in appropriate identification and intervention techniques for students at risk of violent behavior and illegal use of drugs. Expanded and improved school-based mental health services provided by some districts include: illegal drug use and violence prevention, including early identification of violence and illegal drug use, assessment, and direct or group counseling services provided to students, parents, families, and school personnel by qualified school-based mental health service providers. Also, services to support to Individual Education Plans (IEP) are provided. Additionally, the services listed above may be available to the general student population based on the districts resources.

**Interagency Agreement Regarding Transition Services and Post-School Employment Goals**

The Department of Workforce Development (DWD)- Division of Vocational Rehabilitation (DVR), the Department of Public Instruction (DPI)- Division for Learning Support Equity and Advocacy (DLSEA), and the Department of Health Services (DHS)-Division of Long-Term Care (DLTC) and Division of Mental Health and Substance Abuse Services (DMHSAS) are clarifying their relationship in order to establish a common understanding regarding their roles, policies, and procedures related to providing transition services and supports for students with disabilities entering employment.
The purpose of the Department of Public Instruction (DPI)/Department of Health Services (DHS) and Division of Vocational Rehabilitation (DVR) Interagency Agreement is to fulfill interagency agreement mandates found in the Individuals with Disabilities Education Act and the Rehabilitation Act and to coordinate services for individuals transitioning from education to employment.

The agreement between DPI, DHS, and DVR has six overall goals/objectives:

1. to comply with federal legal mandates under the Rehabilitation Act of 1998 and The Individuals with Disabilities Education Act of 2004 (IDEA),
2. to provide practical guidance to school district special and regular education teachers, nurses, psychologists, administrators, and guidance counselors regarding transition services and supports,
3. to provide practical guidance to vocational rehabilitation counselors regarding transition services and supports,
4. to provide practical guidance to counties, Care Management Organizations (CMOs) and Aging Disability Resource Centers (ADRCs) regarding students with disabilities who are transitioning to the adult long term care system and the mental health/substance abuse system,
5. to provide information on transition services to students and their parents so they will be able to participate fully in transition planning, and
6. to provide clarification of roles and responsibilities of staff within school districts, DVR and for entities contracting with DHS (counties and CMOs) regarding students with disabilities, including mental health and substance abuse (MH/SA) issues, who have identified long term needs in employment and independent living.

Educational Services and Employment

For youth in the school system ready for transition services, the primary function of each adolescent’s Individualized Educational Plan (IEP) is to provide assistance, supports, and rehabilitation services to meet their educational and vocational goals. Ideally, these services should be implemented through integrated and wraparound processes and the IEP should reflect and support these processes. Some training on how to provide needed supportive education services, including transition to employment services, is available to schools through the DPI and their contract with the Cooperative Education Service Agencies (CESAs). Other training opportunities for school staff include: the annual Children Come First and Crisis Conferences, the Wisconsin Statewide Transition Initiative, and Transition and Rehabilitation Conferences. Experienced practitioners from within and outside of Wisconsin are trainers at these events, which are strongly focused on the needs of young adults.

DVR has over 200 counselors who are assigned as liaisons to over 400 school districts in Wisconsin. DVR and DPI developed a new interagency agreement for the delivery of vocational services to youth in transition from high school to adult services and employment. DVR and DPI, in cooperation with CESAs, are conducting training on the agreement and new IDEA regulatory provisions around the state. For the first time the Department of Health Services is a partner in this inter-agency agreement.

Barriers to better employment and educational experiences include the lack of advanced planning, insufficient supportive services targeted for youth/adolescents, lack of employment opportunities
both during and post high school, funding, accommodation issues, and stigma. The complexities of work eligibility, fragmentation of services and information around work, earned income, and access to critical health care supports have traditionally made employment outcomes poor. The most common source of initial supported employment funding comes from DVR funding. DVR is currently serving individuals with a waiting list of less than 100 individuals statewide. DVR is now instituting Employment Supports Planning to focus on all possible sources of support so that services are sustainable for each individual referred.

Families and consumers have requested increased access to benefit specialist services and the Benefits Planning, Assistance, and Outreach Program, a five-year demonstration project funded by the Social Security Administration, has accomplished this. They are available to every county and for people with disabilities ages 16 - 64. There are also many fee-for-service benefit counseling services, which can be paid for privately or via community and vocational agency funding, such as DVR funding. These specialists also address housing, food stamps, and health insurance in addition to Supplemental Security Income (SSI) and Social Security Disability Insurance. The Medicaid Purchase Plan and Health and Employment Counseling (HEC) are relatively new programs that make employment more attractive to older teens because these programs provide for health care coverage to those people with disabilities who work, and in the case of HEC, those who are looking for employment.

Substance Abuse Services

DHS continues to seek out the latest research on treatment, prevention, and recovery, and to disseminate information to the substance abuse field for improvement in treatment outcomes. DHS has partnered with the Prairie Lands Addiction Technology Transfer Center. This partnership brings national experts to Wisconsin providers in a teleconference training by researching and incorporating the latest science into its service delivery system. Wisconsin is working hard to support effective prevention and treatment programs by improving the use of evidence-based practices and putting resources behind them. Wisconsin has had an Access to Recovery grant program in Milwaukee. This voucher program provides substance abuse treatment funding for use with evidence-based treatment and supportive services. This grant has brought $22 million federal dollars for services and facilitated a comprehensive substance abuse system which includes: a voucher based treatment provider network; recovery support; and faith based provider services. The Department of Health Services continues to seek out additional federal and other resources to provide additional services.

DMHSAS is focusing efforts to provide increased education and outreach to providers on best-practice integrated treatment services. The third DMHSAS-sponsored conference on integrated services was held in the fall of 2007. All of the DMHSAS conferences since 2005 have had a track for professional development in integrated services. Many county agencies are encouraging their mental health staff to obtain the substance abuse counselor specialty for community services and the Department of Regulation and Licensing and DMHSAS are working together to ensure that the training for the specialty is accessible and flexible.

The CCS benefit was designed to provide integrated mental health and substance abuse services. County programs are just beginning to focus on developing their substance abuse services array.

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

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 3: Children's Services

Directions: Establishes defined geographic area for the provision of the services of such system.

Geographic Area Definition

Description of Wisconsin's Public Local Mental Health System

Wisconsin's public mental health system is administered through 67 county/regional program boards covering all 72 counties using statutory authority to invest each county with responsibility for the delivery of mental health services. The state's mental health system is governed by Chapter 51 of the Wisconsin state statutes. It sets forth the obligations of the state and counties to provide services, the procedures for voluntary admissions of adults and juveniles to inpatient facilities, the standards and procedures for civil commitment, and the rights of persons receiving mental health care. It has a very clear policy in favor of providing a range of services that will enable persons to receive treatment in the least restrictive environment that is most appropriate to their needs. It also has a strong focus on protecting individual rights and liberties and favors voluntary over involuntary treatment.

Wraparound Projects Serving Children with SED in Wisconsin

The Department of Health Services (DHS) is responsible for the coordination of children’s mental health services in Wisconsin, supported by the Departments of Public Instruction, Workforce Development, and Corrections. The DMHSAS is the designated mental health authority. It assumes major responsibility for the planning, monitoring, technical assistance, and training for counties delivering mental health services.

DCF is an umbrella organization and contains child and family-service programs except for those within the Departments of Public Instruction and Workforce Development, and the Division of Juvenile Corrections, which is part of the Department of Corrections, Long Term Care, Medicaid and DMHSAS in DHS. The CST Initiative is intended to blend what were once disparate funding streams and efforts; it is a partnership between DMHSAS and the Department of Children and Families (child welfare), along with other stakeholders at the state and local level. The goal is to implement a collaborative systems change by serving children and their families who are involved in one or more systems including mental health, substance abuse, child welfare, and/or juvenile justice. Expanded emergency crisis services and prevention/early identification activities offer additional opportunities to reduce hospitalization and recidivism.

There are 42 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 a wraparound approach is to increase social supports.
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 ISP, CST, and CCS programs also provide supports and services to enable children with SED to receive services. In addition to the CCS initiative which serves mental health consumers across the lifespan, the Coordinated Services Team (CST) initiative focuses on children involved in multiple systems and in need of mental health and substance abuse services.

Currently, 42 projects receive both ISP and CST funding throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First are funded through a managed care funding structure. 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.

To date, 27 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.
**Process to Receive Services within an Integrated Services Project**

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.

**Child Welfare Services**

Wisconsin’s Child Protective Services (CPS) program is state-supervised and county-administered. Alleged child maltreatment is reported to county human/social services departments in all counties except Milwaukee County, where it is reported to the state Bureau of Milwaukee Child Welfare. The role of the DCF is to supervise the county programs and assure that there are statewide policies and procedures that support the goals of child protective services, child safety and stability of the family.

**Juvenile Justice Services**

In 2002, DMHSAS began delivering tools and system development to support Wisconsin's mental health and substance abuse providers in recognized trauma symptoms for Wisconsin’s youth population. The Wisconsin Office of Justice Assistance funded a grant to cover the costs of developing the tools. This partnership created a training opportunity for both the Juvenile Justice pilots and CST Initiative county sites in the Sidran Foundation model of trauma symptoms identification and treatment model. This collaboration made possible the development of a Wisconsin version of the automated POSIT that identifies trauma indicators, as well as substance abuse, mental health, school, delinquency, and family issues. The Problem Orientated Screening Instrument for Teenagers (POSIT) is a computerized self-administrated, interview questionnaire, that contains 139-items. It is an evidence-based screening tool that identifies low, medium and high risk areas in 10 different domains. The domains include Mental Health issues specific to adolescents. Wisconsin has made the tool available for use in all county Juvenile Justice Unites. 24 counties were interested in using the tool and 18 counties have currently implemented it as part of their juvenile justice intake system.

The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from other Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs. A youth’s motivation for positive change is also part of that assessment. Parents or guardians receive program and treatment reports during a youth’s stay at the MJTC.

**Educational Services**

Wisconsin continues to work collaboratively to provide educational services to children with SED. The Department of Public Instruction (DPI) continues to work on several issues across
multiple systems to improve the success of children with special educational needs who have mental illness or substance abuse disorders. Immediate efforts for focused cooperation can be seen in work through the CST in the eight new CST counties and in the other wraparound counties. DPI administers the Wisconsin Youth Risk Behavior Survey (YRBS) every two years. In 2007, the survey was administered in all public high schools in Wisconsin. The percentage of students who said that they considered suicide has dropped from 27 percent in 1993 to 15 percent in 2007 and the percentage of students who made a plan about how they would attempt suicide during the prior 12 months has decreased from 15 percent in 2005 to 10 percent 2007. The percentage of students who reported they have attempted suicide in the past 12 months has remained steady from 1993 to 2007.

DPI staff continues to work closely with the DMHSAS in many areas. Training occurs through the CESAs, school districts, conferences, and other professional training. A curriculum for identification of mental illness and other emotional/behavioral issues has been developed with emphasis on prevention and early intervention.*

*For detailed information on Educational Services available in Wisconsin for Children with Severe Emotional Disturbances and Other Disabilities, See Section "Available Services--Children."

Anti-Bullying

In recent years school violence has made national headlines. Often bullying is cited as a reason a child lashes out in a violent manner. Bullying is a form of abuse that regularly occurs to some children by other children and adults. Social and emotional competence may serve as a protective factor against becoming a victim of bullying or of becoming a bully. Bullying involves harassment and violence and should not be considered just a part of growing up. It has negative effects on both the perpetrator and the victim. Bullying interferes with learning in school. Children feel less safe and less satisfied in school when there are high levels of bullying. Bullying children may become bullying adults and are more likely to become child and spouse abusers. The longer bullying lasts, the more difficult the behavior is to change. Bullies identified at age eight are six times more likely to have a criminal conviction by age 24. The victims of bullying grow socially insecure and anxious with decreased self-esteem and increased depression rates, even into the adult years (US Department of Health and Human Services, 2003). Children who have good social skills, high self-esteem, and self-confidence are less likely to be bullied. Similarly, children who are raised and nurtured in environments where violence is not acceptable and those who can rely on their caregivers for help dealing with strong emotions, are less likely to become bullies (US Department of Health and Human Services, 2003).

The Wisconsin Department of Public Instruction has recently issued its “Bullying Prevention Policy Guidelines,” including the following recommendations:

- An assessment needs to be conducted to determine the prevalence of bullying, where it is happening, who is involved, and when it is happening.

- Programs must be implemented K–12 and must be comprehensive in nature, including policy, curriculum, and interventions. Administrators must provide strong leadership and commitment for anti-bullying programs to be successful.

- Policy needs to be communicated regularly to students, parents, teachers, and others. Rules against bullying need to be enforced consistently.
- The climate of the school must discourage bullying.
- Parents need to be educated about bullying, and they need to be involved in prevention efforts.
- Quality bullying prevention programming, strategies, and resources need to be developed or purchased.
- Strategies for hot spots such as buses, cafeterias, lavatories, and other locations need to be developed. Environmental redesign may need to be considered. Technological monitoring may be effective.
- Training needs to be provided for administrators, teachers, and all school staff, including cafeteria workers, bus drivers, playground supervisors, and others.
- The district’s computer-use policy needs to include cyber-bullying in the list of unacceptable uses of district equipment.
- Resources need to be identified to assist bullies, victims, bystanders, and families.
- Data must be maintained regarding the effectiveness of bullying prevention efforts.

Socialization of Young Children

In addition to anti-bullying efforts in the state, the Infant Mental Health Initiative targets the early social-emotional development of children aged 0-5.

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 stakeholders.

IMHLT POLICY RECOMMENDATIONS

1. Early identification of social emotional delays in children under the age of five should be implemented through a universal screening DHS protocol.
1. Utilization of DC:0-3R should be encouraged and monitored. Technical assistance should be provided based on data showing need for increased capacity or training, including need for training within state departments.

2. Information on early childhood mental health should be disseminated to mental health providers, early childhood workers, public policy makers and other stakeholders.

3. Infant and early childhood principles and practices should be integrated across Divisions in DHS as well as other Departments and stakeholders.

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

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

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless
Section III. Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 4: Targeted Services to Homeless, Children's Population

Directions: Describe State's outreach to and services for individuals who are homeless.

Outreach to Homeless

Children Who are Homeless and Have a Serious Mental illness

The Division of Mental Health and Substance Abuse Services (DMHSAS) is committed to the inclusion of homeless individuals in the system of services and supports Wisconsin offers to residents with mental health and substance abuse issues.

Issues Related to Affordability of Housing for Low-Income Women and Children in Wisconsin

Although there are supportive housing programs in Wisconsin, there is a paucity in low-income housing stock and subsidized housing vouchers. This makes it difficult for low-income families (many of which have adults and children suffering from mental health problems) to secure and keep housing.

- It is very difficult to build housing in Wisconsin that a low-income family can afford without somebody heavily subsidizing either the developer or the family who ends up buying or renting the unit. The sum of the costs of land, construction, financing and various other fees involved in creating a unit of housing do not match up with what low-wage workers make in the current labor market. The ability of low-income people to pay for their housing needs to be enhanced by expanding income support programs like the Earned Income Tax Credit or housing subsidies like the federal Section 8 voucher program; and by targeting greater federal resources toward the development of housing that is affordable to families at the lowest end of the income distribution.

- The Section 8 program's goal was to allow low-income people to rent in the open market and provide them with opportunities to be integrated into the community. There are many problems with the program in Wisconsin and other states. Waiting lists are common and vary from weeks to years in length. The major problem with waiting lists is that tenants are often purged from the list when the housing authority loses contact with them. This happens frequently because tenants who need housing assistance move often. There has also been major landlord opposition to the Section 8 program because in the past a "lease in perpetuity" was required. Although this is no longer the case, some landlords are not aware of this change. Also, some landlords believe that if they accept one Section 8 tenant, they must take all others that apply. This is not true, but adds to the stigma of the program. Additionally, landlords object to having to collect rent directly
from tenants as a large proportion of the tenants are below the poverty line and are therefore "uncollectible," meaning their wages and assets cannot be garnished. Finally, many landlords continue to object to the program because they do not want to sign the HUD lease or be subject to rules that HUD may change during the lease period. Some landlords are also hesitant to let housing authority building inspectors in to inspect the unit, and many do not want to make the repairs that are required in order to rent to a Section 8 tenant.

Homeless Children in Wisconsin

As a result of the affordable housing shortage in Wisconsin, there are a significant number of homeless families with children. Again, many of these families suffer from mental health issues and the lack of housing compounds their stress.

There were at least 8,957 homeless students in Wisconsin at some point during the last school year, up 67 percent from 5,358 in 2003-04. The Department of Public Instruction (DPI) reports a high volume of calls from school districts for information and advice regarding this issue during the current school year. DPI reports that the Milwaukee Public School District counted 870 homeless students after reporting a total of 2,400 at the end of 2007. The poor economy and a large number of foreclosures, including foreclosed apartment buildings, could be driving the increase. Another factor could be the number of families displaced by flooding in June.

A report by First Focus, a children's advocacy organization based in Washington, D.C., states that two million children nationally will be directly affected by the mortgage crisis as their families lose their homes due to foreclosures. That figure did not include evictions from rental units that were foreclosed. A state-by-state estimate by First Focus projects 26,334 foreclosures in Wisconsin, with 44 percent affecting a total of 22,600 children.

Each public school district in Wisconsin is required to designate a homeless liaison to identify, immediately enroll, and help homeless children and unaccompanied youth stay in school. Wisconsin homeless liaisons follow legislative requirements to help children and youth in homeless situations continue their education.

In August 2009, Governor Jim Doyle and State Superintendent Tony Evers announced $1.6 million in competitive grants to Wisconsin schools to support families and students who are homeless. Over half of this funding comes from the American Recovery and Reinvestment Act (ARRA). “Over the last five years, the number of homeless students in Wisconsin has increased 74 percent,” Evers noted. Wisconsin school districts are receiving $904,290 in homeless funding through ARRA and $688,200 through the federal Education for Homeless Children and Youth (EHCY) program. Historically, Wisconsin has been able to fund a maximum of 12 districts with EHCY funds. With the addition of ARRA funding, this year a total of 30 Wisconsin districts will receive EHCY grant funds to support homeless students and families. They will use the funds for a variety of purposes, from accurately identifying students who are homeless and ensuring immediate enrollment, to providing free school meals, school supplies, and course fee waivers.

Mental Health Block Grant and County Reporting

The Division of Mental Health and Substance Abuse Services is committed to the inclusion of homeless individuals in the system of services and supports Wisconsin offers to residents with mental health and substance abuse issues.
County mental health and systems are required to report numbers of homeless people with mental illness served at the local level on the Human Services Reporting System (HSRS). The Division’s state county contracts require that counties serve the homeless as a priority population. The following data was taken from the HSRS mental health module for 2008. All the individuals listed received mental health services in 2008.

**Received a Mental Health Service during 2008 and Residential Arrangement was Street or Shelter**

<table>
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<tr>
<th></th>
<th>Total</th>
<th>Under 21</th>
<th>21-59</th>
<th>60+</th>
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<td>1,277</td>
<td>69</td>
<td>1,123</td>
<td>85</td>
</tr>
</tbody>
</table>

One of the more critical components for this population is outreach and access. Typically homeless individuals do not seek out services and often do not have benefits or the benefits have lapsed due to a number of factors. The Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) has a memorandum of agreement 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 objectives 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 Diversion 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.

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

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.

- 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 template.

**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
- Emergency response

*Refer to Section "Available Services Adults" for more detail on ADRC's.

Additionally, in Wisconsin, the Community Support Program was adopted as the framework for
developing a comprehensive range of services that would allow people with SMI to live
successfully outside of institutions. Many individuals who are homeless meet the criteria for the
two priority target populations—(a) persons who need ongoing low intensity, comprehensive
services; and (b) persons who need ongoing, high intensity, comprehensive services. However,
the number of people in need of services far exceeds the capacity of the programs that are
supposed to serve them. As a result, many people with SMI receive fragmented and
uncoordinated treatment, housing, and support services, if they receive them at all. They may
cycle in and out of hospitals, jails, shelters, and life on the street at enormous cost to both
themselves and their communities.

To address some of this need, Comprehensive Community Services initiatives are also being
implemented across the state. For example, the Administrator of the Division of Mental Health
and Substance Abuse Services and the Bureau’s Coordinator of Comprehensive Community
Services are serving as a resource to the Milwaukee Division of Behavioral Health and other
stakeholders on their Special Needs Housing Action Team. The team has formed to do the
following:

- Support Milwaukee Continuum of Care in its efforts to maximize the amount of HUD
  funding coming to Milwaukee County for housing development projects that serve
  homeless and special needs populations.
• Assess the local affordable special needs housing infrastructure, identifying the biggest
gaps in that infrastructure, define the highest priority need, and develop a vision and
roadmap for creating a sufficient supply of safe, decent and affordable housing for
Milwaukee County’s most vulnerable residents.
• Develop practical strategies to help housing developers assemble the elements needed for
successful special needs housing: sites, financing, and services that support residents.
• Identify and establish strategies to secure the diverse range of fiscal resources that will be
necessary for the continued development and support of affordable housing for persons
suffering from mental illness and/or substance abuse, including non-governmental
sources of funding from foundations, corporate donors, etc.

The DMHSAS continues to collaborate with the Division of Health Care Access and
Accountability (DHCAA) to assure access to services through the SSI Managed Care statewide
initiative which offers all primary and acute care services in the state plan to all individuals with
SSI or SSI related disability funding. The DMHSAS is helping counties write memorandums of
agreement with the Health Maintenance Organizations (HMO) involved, and assisting with
access issues for consumers.

The DMHSAS remains committed to seeking opportunities to promote services delivery to the
mental health individuals who are homeless with their partners at the county level and other
willing providers.

Over the past 4 decades, the care of people with serious mental illness (SMI) has shifted from
state and county hospitals to the community. Deinstitutionalization sought to provide treatment
for people with mental illness in the least restrictive setting. However, the reality that people with
serious mental illness face in the community is in stark contrast to the promise of
deinstitutionalization. The vast array of services and supports that people with serious mental
illness need in order to survive in the community has not materialized.

Homelessness is typically more than being without a home. Persons with serious mental illnesses
who are homeless are often unattached from mainstream society on a number of dimensions
including health care, employment, connection with family and friends and the broader
community. Many individuals present with co-occurring disorders of mental illness and substance
abuse, and a history of trauma, which impairs their ability to function. People with SMI and/or
coccurring substance abuse disorders become homeless because they are poor, and mainstream
health, mental health, housing, vocational, and social service programs are unwilling or unable to
serve them. People with both disorders are at greater risk for homelessness because they tend to
have more severe mental health symptoms, to deny both their mental illness and their substance
abuse problems, to refuse treatment and medication, and to abuse multiple substances. They are
subject to ongoing discrimination, stigma, and even violence. The lack of appropriate treatment
for co-occurring disorders means that even individuals who are motivated to get help may be
unable to find it or have to face long waits for services.

There is also a well-documented relationship between homelessness, mental illness, substance
abuse and victimization. People who have been abused are more vulnerable to ongoing stresses
that may lead to mental illness, substance abuse and homelessness. Research shows that as many
as 97 percent of women with serious mental illness report some form of physical or sexual abuse;
over 70 percent of women in treatment for drug or alcohol disorders report being sexually abused
as children or adults, and over a third have been victims of violent crime.
Abuse in childhood may leave individuals vulnerable to ongoing abuse in adult relationships. People with SMI and/or co-occurring substance abuse disorders living on the streets or in shelters are frequently victims of criminal activity. Poverty and poor survival skills place them in dangerous situations in which they are vulnerable to attack. Individuals with SMI have fewer skills and resources to overcome the effects of trauma, and are particularly likely to be victimized while homeless, and to suffer more severe consequences of ongoing abuse. These individuals require trauma sensitive services to help them regain psychiatric and residential stability.

In Wisconsin, the Community Support Program was adopted as the framework for developing a comprehensive range of services that would allow people with SMI to live successfully outside of institutions. Many individuals who are homeless meet the criteria for the two priority target populations: (a) persons who need ongoing low intensity, comprehensive services; and (b) persons who need ongoing, high intensity, comprehensive services. However, the number of people in need of services far exceeds the capacity of the programs that are supposed to serve them. As a result, many people with SMI receive fragmented and uncoordinated treatment, housing, and support services, if they receive them at all. They may cycle in and out of hospitals, jails, shelters, and life on the street at enormous cost to both themselves and their communities. A conservative estimate by the National Resource Center on Homelessness and Mental Illness suggests that there are at least 7,500 adults with serious mental illnesses who are homeless in Wisconsin.

Projects for Assistance in Transition from Homelessness

Projects for Assistance in Transition from Homelessness (PATH) funding continues to be administered through The Department of Commerce, Division of Housing and Community Development, Bureau of Supportive Housing. Also continuing is a Memorandum of Understanding between DHS and the Department of Commerce that contains 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 will 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 (5) programs in areas of the state with some of the largest populations of people who have SMI and are homeless. These programs include: 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 mental illness. Assistance was provided to over 2000 of these people.

PATH funds are being utilized to provide training on the Social Security application process. The majority of individuals who have serious 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 these people not to stay in one place very long often impedes simply having application submitted. Approval of an application is rare.

PATH funds, combined with Mental Health Block Grant funds, ($74,000 for 2008) was 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, 60 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 have developed SOAR training teams who have attended national training and are qualified to teach service providers to utilize the SOAR model to assist their clients in applying for SSI/SSDI. In 2008, close to 150 people were trained to implement the SOAR model in their communities. These trainings will continue 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 understands 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 these objectives can be accomplished through the development of a SOAR Program Task Force, which will convene for the first time at the upcoming Wisconsin PATH Conference.

PATH funds continued 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 being used to hold a Wisconsin PATH Conference. Over 50 service providers representing five PATH-funded and more than 20 non-PATH-funded agencies will be attending the conference. The keynote speaker for the event is a nationally known speaker who will provide 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 PATH funding will again be administered by the Wisconsin Department of Commerce. The funds are being awarded through a Request for Proposal (RFP) process. The five current grantees applied and an additional three new agencies submitted applications. Funding announcements will be made by the middle of May 2009.

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. All HUD funded homeless programs participate in the Homeless Management Information System known in Wisconsin as Wisconsin Service Point (WISP). The PATH programs will use 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 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.

WISP is the State of Wisconsin's Homeless Management Information System (HMIS). The system has been in operation since May of 2001 and has more than 250,000 active client files. The system is used for all HUD McKinney-Vento funded programs as well as several state homeless grant programs. WISP is also used by all PATH funded projects in Wisconsin to track client outcomes. By the end of 2008, all PATH funded projects in Wisconsin were actively using WISP. In 2009, The Department of Commerce expanded the use of WISP to include SOAR funded projects.

Crisis Services for Homeless Individuals and Families

There are 31 counties that operate certified crisis programs under Wisconsin statutes DHS 34. Crisis programs provide some of the initial outreach and services to individuals and families who are homeless. The crisis stabilization programs will do initial assessments to determine mental health needs and make referrals to appropriate services.

Evidence Based Practices Pilots Impact on Homelessness

Additionally, Marathon County North Central Health Care has piloted quality improvement activities related to Integrated Dual Diagnosis Treatment (IDDT). During 2007 through 2008 the project reported that quarterly outcomes were collected using the consumer report forms. Trends in the data include reduced homelessness and reduced hospitalizations for substance abuse. Although there was a reported increased enrollment for IDDT, it appears difficult for some consumers to complete the group process in the desired time frame due to relapse. Some additions were added to the report forms in 2008 including differentiating between substances
being abused (alcohol, marijuana, nicotine, etc.). Additionally, IMR groups will begin in Langlade County at the end of the first quarter.
Wisconsin

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

   Criterion 4: Targeted Services to Rural Populations

   Directions: Describe how community-based services will be provided to individuals in rural areas.

Rural Populations

Targeted Services for Rural Populations

Chapter 51, Wis. Stats., mandates that mental health service needs be identified, budgeted for, and provided at the local level in all 72 counties. Numerical size of the county is not a distinction made within the law. The identified need of the citizen residing in the county is the determinant for service response.

Definition of a Rural Area

Wisconsin's definition of a rural area is based on the definition of an urban area. A rural area is a county not classified as a "metropolitan area," as defined by the State and Metropolitan Area Data Book, 5th Edition 1997 – 1998, US Department of Commerce, Economics and Statistics Administration, Bureau of the Census. Using the Census Bureau’s definition of a metropolitan area containing a place with a population of 50,000 or greater, Wisconsin has 14 urban counties (19 percent) and 58 rural counties (81 percent). The urban counties identified using this definition include Milwaukee, Dane, Brown, Outagamie, Rock, Eau Claire, Fond du Lac, Kenosha, Racine, La Crosse, Waukesha, Winnebago, Sheboygan, and Marathon. All other counties are considered rural for the purpose of discussing targeted mental health services in this section.

Both rural and inner city areas of Wisconsin encounter access issues due to the uneven distribution of the health care workforce and a fragile health care infrastructure. A significant number of communities are federally designated as health professional shortage areas. These include parts of larger cities, large numbers of rural areas throughout the state, most tribal populations, and low-income populations. For example, considerable variation exists in levels and quality of emergency medical services in rural Wisconsin (National Conference of State Legislators, August 2000). Some very rural counties in Wisconsin have severe shortages of primary care, dental, and mental health providers. There is a shortage of providers who will supply health care to low-income and MA populations.

Challenges to the Provision of Rural Mental Health Services

Wisconsin's community mental health system has resource limitations. Work force shortages stem to a great degree from low population densities in the extensive rural parts of the state (see Section II for a description of Wisconsin's geography). In rural, less densely populated counties, county-based mental health programs often lack the immediate availability and access to
psychiatric and psychological services. Transportation is often a barrier for consumers and their families. A lack of public transportation especially limits their ability to attend peer and family support programs. These limitations result in the lack of choice of mental health and substance abuse providers. Specific areas of need include mental health evaluation, assessment, medication management, treatment, and review.

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 without the psychiatrist even seeing a consumer. To meet this challenge, Wisconsin is moving forward with allowing MA-reimbursement for mental health services provided through tele-health technology.

**Rural Mental Health Services**

Tele-health is defined as the use of telecommunication equipment to link mental health and/or substance abuse providers and consumers in different locations. The use of tele-health technology to improve access to mental health services for individuals in rural areas of the state is in accordance with Goal 6 of the NFC, which envisions the use of technology to increase access to services. Tele-health will allow the county to more easily attract a qualified psychiatrist and pay only for the time the person is actually seeing consumers. In addition, if the consumer is in need of hospitalization, the psychiatrist may be more available, through tele-health consultation, to the admitting hospital, as well as to the other treatment professionals, family members, and natural supports.

Tele-health will also enhance the ability of small, remote, rural counties to access specialty services such as child and geriatric psychiatry. This technology should assist in better diagnostic services, medication determinations, and more successful treatment planning for those individuals most in need. Tele-health services can be provided to consumers involved in any certified mental health and/or substance abuse program, such as outpatient services, crisis services, community support services, day treatment programs, and inpatient services. All staff employed by these programs may provide services via tele-health, provided they have received the necessary training and meet program certification standards. The state Medicaid program will reimburse for MA-covered services delivered via tele-health in the same way it reimburses for face-to-face contacts provided that certain requirements are met.

Another opportunity for rural providers is the Wisconsin Public Psychiatry Project, which has been operating a bi-weekly teleconference since June of 1995. The project is a collaborative effort between the Bureau 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.
In 2008, BPTR also provided the 4th Annual Mental Health and Substance Abuse Training Conference "Recovery: Promoting Dreams Through Evidence-Based Practice." The goal of the conference was to provide training on clinical and evidence-based approaches and a forum for providers, advocates, consumers and administrators to network and exchange ideas. The conference, held on October 22-23, 2008 provided 24 workshops. The 2009 BPTR Conference "Celebrating Strengths in Challenging Times" will be held on October 27-28, 2009 and will provide 30 workshops. The conference will provide training on topics ranging from community strategies for substance abuse prevention, seclusion and restraint, trauma informed care, advocacy in mental health psycho-pharmacology, cultural competence in substance abuse treatment, overview of Person-Centered-Planning, addiction in the elderly, integration of CSP and CSS in Family Care and others.

University of Wisconsin Department of Psychiatry staff also provided clinical Mental Health information and background to Department of Health Services pharmacy committees, Comprehensive Community Services programs, and the Center for Best Practice Development initiatives.

**Addressing Workforce Development**

Wisconsin recognizes the need to improve recruitment, retention and training of mental health professionals along a spectrum of education and experience regarding rural health care. It is critical to grow the local workforce, meaning to educate, train, recruit and retain mental health professionals in order to meet and sustain the demand for competent rural health care.

**Background**

The Wisconsin Division of Mental Health and Substance Abuse (DMHSAS) in partnership with counties, provider, consumers and families are moving towards a more recovery based system for children and adults. The guiding principles of this system include but are not limited to: recovery, hope, outcome based, strength based, consumer/family involvement and empowerment. Examples of programs being implemented that focus on these values and principles include Comprehensive Community Services (CCS), Coordinated Service Teams (CST), Integrated Service Programs (ISP) and Crisis Intervention Services. But these implementation efforts are somewhat jeopardized by the lack of psychiatric expertise in recovery based systems of care and availability of time to provide direct services.

This is especially true in the area of specialty psychiatrists – child and geriatric. The issue of lack of child psychiatry has been brought to the attention of the Secretary of the Department of Health Services by the Child Come First Advisory Committee, the CST Advisory Committee and a group of concerned provider, consumers and other interested parties in Northern Wisconsin.

The goals of this initiative are as follows:

1. Educate stakeholders and policy makers on psychiatric shortages in Wisconsin and nationally.

2. Share information with summit participant on what is being done in other states to address psychiatric shortages.

3. Identify all issues that prevent the hiring of skilled psychiatrist in all areas of Wisconsin.
4. Identify ways to recruit psychiatrist with skills necessary to serve all residents in the state or alternatives methods of assuring that residents with mental health needs have access to quality medical professionals that can meet their needs and wants.

5. Identify individuals and agencies/organizations in the state and elsewhere that DMHSAS should partner with to address these issues.

6. Develop prototype tele-psychiatry services focused on filling critical gaps in public mental health programs.

Outcomes

1. DMHSAS will have a list of individuals and agencies/organizations they can begin to work with to resolve issues around psychiatric shortages.

2. Issues will be identified with an action plan to address problems in the short term and long range to ensure all Wisconsin residents have access to psychiatric care that meets their needs and wants.

Addressing Psychiatric Shortage Problems in Wisconsin

Wisconsin, like many states, is experiencing an ongoing shortage of highly trained mental health professionals. This shortage is further exacerbated by mal-distribution, with rural counties unable to attract critically needed mental health professionals despite salaries competitive with urban areas. This shortage results in long wait lists, excessive and inappropriate use of hospitalization and emergency services, stress and burnout in the existing workforce, ineffective treatment interventions as primary care generalists attempt to treat complex mental health problems, excessive disability and suffering.

Tele-Mental Health Initiative

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.

The richness of expertise and experience at the University of Wisconsin-Madison (UW-Madison) stands in sharp contrast to the dearth of mental health resources in rural Wisconsin. Indeed, this might be viewed as an extreme example of resource mal-distribution. The overarching objective of the initiative is to bring rich resources of UW-Madison to rural Wisconsin via audio and video communication technologies.

A three-pronged approach will be used: (a) a tele-health clinic 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 enhance 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 staffed by a highly trained and experienced medical/mental health librarian.

This project will build upon 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).

The following are specific objectives by grant year:

- **Year 1.** 500 hours of direct tele-mental health services to rural counties, four evidence-based distance education programs, MHERC contact with all 72 counties;
- **Year 2.** As in Year 1, plus an additional 1,000 hours of direct tele-mental health services utilizing supervised trainees;
- **Year 3.** As in Years 1 and 2, plus (a) expansion to subspecialties, including geriatric psychiatry, substance abuse, and child psychiatry, and (b) work on sustainability issues, including further grants and fee-for-service operations.

The goal of the initiative is to reduce the disability and suffering that result from the inadequate treatment of mental illness. More specifically, this project is designed to remediate inadequate treatment that occurs in rural Wisconsin as result of mental health as a result of mental health specialist workforce shortages. The project will target this inadequate treatment via three distinct approaches:

- **Bringing well-qualified specialists to rural communities.** The project will provide specialists to rural communities using real-time, interactive audio and visual communications technologies.
- **Enhancing the exiting workforce.** The project will deliver quarterly professional development workshops focused on new developments in evidence-based practice. These workshops will be delivered via the above communications technologies.
- **Responding to and assisting the existing workforce.** The project will provide meaningful access to the published scientific literature on mental disorders and their treatment through the services of the Mental Health and Education Resource Center (MHERC).

**Outreach to Children in Rural Areas**

As Wisconsin is a primarily rural state, the less densely populated and expansive rural counties have made it necessary to develop ways to make contact with families and their children with serious emotional disturbance. Much of the outreach has been accomplished through children and family mental health advocacy agencies, networking between parents and natural supports through a wraparound approach to community mental health care.

**Advocacy - Wisconsin Family Ties**

Wisconsin Family Ties, Inc. (WFT) is a statewide, not-for-profit organization run by families for families that include children and adolescents who have emotional, behavioral and mental disorders. Their mission is to provide greater understanding, acceptance, and support in the community for families having children and adolescents with emotional, behavioral and mental disorders. WFT is supported by the Division of Mental Health and Substance Abuse Services and affiliated with the National Federation of Families.
Wisconsin Family Ties has family advocates who team with families and the professionals working with them. They work with schools, social services, mental health services, or the juvenile justice system, and help families locate resources clarify options and understand their rights. WFT has parent representatives involved on the local, state, and national level to build awareness.

Wisconsin Family Ties helps families find support groups in their area or helps parents start one. Families can share challenges and possible solutions with other families. This enables families with children who have SED in both urban and rural areas of the state to better access resources, services and find emotional support.

Wisconsin Family Ties aids families and professionals to find important and up-to-date information on laws, school issues, behavioral and emotional disorders, and other resources. Wisconsin Family Ties provides:

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

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

**A Wraparound Approach to Community Mental Health and Substance Abuse in Rural Areas**

Since the late '80s, Wisconsin has been implementing a "wraparound" approach to community mental health for families and their children with SED. The initiatives utilizing this approach include: Integrated Services Projects (ISPs); Coordinated Services Teams (CSTs), and Comprehensive Community Services (CCS). The "wraparound" approach utilizes a child and family team made up of team members who provide formal and informal support. The parents and child's needs and strengths drive the plan of care. Team members often include mental health professionals and professionals from other systems of care such as education and child welfare, as well as "informally" supportive people such as other relatives, clergy or neighbors.

In rural areas, the approach of utilizing informal or "natural" supports to help a child and family meet their goals for recovery in the community has been critical. Because mental health provider capacity and availability to child/adolescent psychiatrists are inadequate to meet needs in rural areas, reliance on community neighbors and other families becomes very important. This approach is reflective of the concept "it takes a whole village to raise a child."

**Community-Based Services for Children in Rural Areas**

Wisconsin has a county-based public mental health system. Under statute 51.42, all counties are required to provide community-based services to both children and adults in both urban and rural areas. The county board of supervisors has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This
primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds. Services provided include:

- Collaborative and cooperative services with public health and other groups for programs of prevention.
- Comprehensive diagnostic and evaluation services, including assessment as specified under ss. 343.30 (1q) and 343.305 (10) and assessments under ss. 48.295 (1) and 938.295 (1).
- Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services.
- Related research and staff in-service training, including periodic training on emergency detention procedures under s. 51.15, emergency protective services under s 55.13, and emergency protective placement procedures under s. 55.135, for persons within the jurisdiction of the county department of community programs who are authorized to take individuals into custody under ss. 51.15 and 55.135. In developing in-service training on emergency detention and emergency protective placement procedures, the county department of community programs shall consult the county department of developmental disabilities services under 51.437 in counties where these departments are separate.
- Continuous planning, development and evaluation of programs and services for all population groups.

Medicaid and other funded community-based mental health services for children in rural areas are brokered collaborative systems of care through the Coordinated Services Team (CST), Integrated Services Project (ISP), and Comprehensive Community Services (CCS) initiatives.

**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 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.

**CST**

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.

**ISP**
Since 1989 with the creation of Sec. 46.56 of the Wisconsin State Statutes, Wisconsin has been developing Integrated Services Projects. ISPs utilize a "wraparound" process that "wraps" an individualized, comprehensive, flexible array of services and supports around a child and family, determined by an interactive assessment of their unique strengths and needs. The goal is to help children with SED remain with their families and in their communities. This is accomplished through the provision of cost effective, organized, integrated community-based services and natural supports. The wraparound process is a "systems" approach, the approach cited in the Surgeon General's 1999 Mental Health Report's Executive Summary as "the way to best address the multiple problems associated with children and adolescents with SED."

**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 new services are known as Comprehensive Community Services (CCS). The new rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to both children and adults, including elders, 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.
Wisconsin

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

Criterion 5: Management Systems

Directions: Describes financial resources, staffing and training for mental health services providers necessary for the plan.

Resources for Providers

The DMHSAS is the designated mental health authority. The DMHSAS is responsible for funding, setting policy, and establishing program standards for public mental health services for adults with SMI and children with SED. Although there are many collaborators within and outside of state government that assist in the implementation of Wisconsin’s State Mental Health Plan, the DMHSAS has primary responsibility for development and implementation.

Financial Resources, Staffing, and Training

DMHSAS Staff (Mental Health Authority)

The Division of Mental Health and Substance Abuse Services (DMHSAS) is the designated State Mental Health Authority that directs public mental health services in Wisconsin. The Division is comprised of the Division Administrator, John Easterday, the Deputy Administrator, an office assistant, three program units, and four direct care facilities. The Bureau of Prevention, Treatment, and Recovery (BPTR) is one of the three program units and is responsible for activities related to implementation of the Community Mental Health Services Block Grant (MHBG). The BPTR currently consists of three Sections and 33.9 FTE’s including the Director and the Director’s Office Associate.

Bureau of Prevention Treatment and Recovery

The Mental Health Services and Contracts Section is responsible for monitoring the programmatic and administrative guidelines for the provision of mental health outpatient services throughout the state. The section plans and monitors the implementation of the MHBG including the creation of the federally-required annual Mental Health Plan and Implementation Reports. Staffing for the Wisconsin Council on Mental Health is provided by this section. Some integrated MH/Substance Abuse functions are the responsibility of the Mental Health Services and Contracts Section. The section is responsible for mental health and substance abuse programming for the deaf and hard of hearing and Pre Admissions Screening Resident Review (PASRR). The Mental Health Services and Contracts Section monitors CSPs for adults with severe and persistent mental illness reside as well as programs that target housing and staff coordinate with the Department of Commerce on homeless issues. Finally, all evaluation and contract processing functions for mental health and substance abuse reside in this section including the management of the Human Services Reporting System (HSRS), Data Infrastructure
Grant (DIG) projects, evaluation design, and data analysis. The Mental Health Services and Contracts Section has 6.5 FTE’s and a .5 LTE.

The Substance Abuse Services Section provides a focus for services and programs designed primarily for substance abuse consumers. Substance abuse and prevention programs have been consolidated within this section from across the bureau and include oversight of the substance abuse administrative rules, Access to Recovery, methadone programs, the Intoxicated Driver Program (IDP) and the injection drug use program. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is administered from the Substance Abuse Services Section. The Substance Abuse Prevention and Treatment State Plan (SAPTBG application) is written and monitored in this section and staff provide general oversight in the implementation of the plan. Staffing for the State Council on Alcohol and Other Drug Abuse (SCAODA) is provided from this section. Responsibility for substance abuse prevention programming also resides in this Section. The Substance Abuse Services Section has 9.0 FTE’s.

The Integrated Systems Development Section is responsible for mental health and substance abuse programs and services at both the systems-level and client-level. The section has two units and a total of 11.4 FTE’s and one .5 LTE. The Children, Youth, and Families Unit has a Unit Supervisor that directly supervises the unit staff and reports to the Section Chief. The Section Chief directly supervises the Systems Transformation Unit and has overall responsibility for both units. The programs and services in this section have an integrated MH/Substance Abuse focus and strengthen a new integrated MH/Substance Abuse approach.

The Children, Youth, and Families Unit addresses the special needs of children, and families who have substance abuse and/or mental health disorders. One of the primary functions of the Women, Youth, and Families Unit is to address the goals of the Governor’s KidsFirst Initiative. An example of a program in the unit is Coordinated Service Teams (CST) for children with serious emotional disturbance (SED) that provide a comprehensive systems approach to case management for children that are involved with more than one system of care. All children’s mental health and substance abuse programs and services are consolidated in this unit.

Staff in the Children, Youth and Families unit with mental health and substance abuse expertise work together to strengthen existing integrated MH/Substance Abuse approaches and implement new integrated approaches where needed. Staff provides contract monitoring, technical assistance, training, and programmatic guidance to the Integrated Service Projects, Coordinated Service Teams, and Hospital Diversion programs targeted for children with SED who may also have substance abuse disorders. The unit is responsible for the Child Welfare Initiatives, prevention and early intervention programs to benefit infants such as the Infant Mental Health Initiative. Unit staff also implement and monitor the new CCS benefit for children; provide clinical consultation services for consumers with substance abuse and/or mental health disorders; monitor agencies that provide services to children with SED and monitor child and family advocacy activities.

The Systems Transformation Unit is responsible for implementing and monitoring initiatives for adult mental health and substance abuse service systems. Most initiatives in this unit will focus on systems development and training for local administrators and providers on substance abuse and mental health treatment. Unit staff focus on the implementation of evidence based practices within the system of care across Wisconsin for children with serious emotional disorders and adults with serious mental health disorders. Unit staff will continue to implement and monitor the MH/Substance Abuse Transformation Initiative with a focus on integrated MH/Substance Abuse
screening and treatment, managed care, quality improvement, and the promotion of recovery focused services and systems.

Monitoring the implementation and development of recovery-based outcomes is conducted through contracts and support to the Recovery Implementation Task Force. Finally, responsibilities for monitoring Community Support Programs (CSP) and Comprehensive Community Services (CCS) for adults and children with serious illnesses reside in the Systems

State Mental Health Institutes

Mendota Mental Health Institute, a psychiatric hospital operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services, specializes in serving patients with complex psychiatric conditions, often combined with certain problem behaviors. Mendota provides a secure setting to meet the legal and behavioral needs of our patients. Mendota also operates outpatient treatment services for individuals in the community.

Winnebago Mental Health Institute is a psychiatric hospital owned and operated by the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. Winnebago specializes in serving children, adolescents and adults with complex psychiatric conditions that are often combined with challenging behaviors. Winnebago provides a secure setting to meet the legal, behavioral, treatment and recovery needs of patients.

Secure Treatment Facilities

The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs. A youth’s motivation for positive change is also part of that assessment. Parents or guardians receive program and treatment review reports during a youth’s stay on MJTC.

Sand Ridge Secure Treatment Center offers a range of treatment programs for its patients designed to meet the specific needs of sexually violent persons. The inpatient treatment program consists of several phases and components with a multi-disciplinary approach. It is based on a psycho-social rehab model with an emphasis on cognitive-behavioral and relapse prevention techniques. The length of time in treatment is dependent upon successful program completion as evidenced by the patient's consistent demonstration of mastery of self-management skills.

The Wisconsin Resource Center (WRC) is administered by the Wisconsin Department of Health Services in partnership with the Wisconsin Department of Corrections. WRC is a specialized mental health facility established as a prison under s. 46.056, Wisconsin Statutes. WRC is also identified as a treatment facility for the placement of Sexually Violent Persons (SVPs) detained or admitted pursuant to Chapter 980, Wisconsin Statutes. The facility operates as a secure treatment center and is managed by the Division of Mental Health and Substance Abuse Services. The budgeted capacity of WRC is 404: 344 male inmates transferred from Wisconsin Department of Corrections (DOC) Division of Adult Institution prisons for mental health care and 120 men detained or committed under the SVP program pursuant to Chapter 980 of the Wisconsin Statutes.

Technical Assistance
In addition to DMHSAS staff, the DMHSAS also relies on technical assistance the University of Wisconsin and other agencies provide. Mental Health Block Grant monies are used to fund an expert peer consultant and training for the development of CST initiatives for children. The DMHSAS also funds technical assistance to developing CCS programs to provide leadership on promoting positive behavior supports and to develop trauma sensitive and specific services.

One major area of training offered to mental health service providers every year is on the principles and implementation of "recovery." The DMHSAS partners with the UW-Madison School of Medicine and Public Health to provide recovery technical assistance and will continue to work with a Recovery Task Force to develop "recovery" training curriculums for providers. One type of training to be offered is "recovery awareness" training which is the first step in orienting providers to the principles of "recovery." Practitioner competency training sessions also are offered by the Recovery Coordinator to provide more in-depth training on implementing "recovery" principles into providers’ work. A third type of training, called Guided Reflections is offered to organizations as a whole on "recovery" principles including providers, administrators, and case managers.

A fourth and final training on Recovery for providers is a recovery-oriented boundaries and ethics training for social workers. Disability Rights Wisconsin (DRW) develops and provides some of these Recovery trainings.

**ISP/CST Support**

As part of a MHBG Training/Consultation Fund administered through Wisconsin Council on Children and Families (WCCF), training and technical assistance was provided to Coordinated Services Teams (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.

Additionally in 2008, each of the five regions with ISP/CST projects in the state sponsored two regional meetings. These meetings were well attended by county and private representatives of the local projects. Approximately 25 people attended five meetings, two times per year. State staff teamed with Area Administration staff and wraparound consultants to prepare for and lead these local meetings. These smaller meetings addressed issues raised by the regional sites in a more directed and focused approach.

Also, White Pine Consulting Service (WPCS) works with consultants from across the State who work with the CST sites to identify and address needs. Training and Technical Assistance meetings were held 10/8/07, 12/10/07, and 4/28/08 for consultants and the Project Specialist to discuss local, regional, and statewide training and technical assistance needs of sites. Highlights of agenda included: working with sites with multiple collaborative initiatives, including Comprehensive Community Services; new CST site development; transitioning; and handbook and curriculum development.

As of September 30, 2008, each CST site completed either an initial (for newly funded sites) or updated Goals and Expected Outcomes Checklist which evaluated each site in the following three areas: system outcomes supporting CST; process outcomes supporting CST; and family-specific outcomes. WPCS consultants established visitation plans with developing CST sites, including attendance at Coordinating Committee meetings as well as training and coaching visits. During
the visits the fidelity, training, and technical assistance tools were available to address questions or concerns.

As-needed technical assistance was also provided to CST sites. Assistance was provided by our cadre of consultants to sites in the areas of: CST development, role and responsibilities of the coordinating committee, process and financial sustainability, managing several collaborative initiatives; teaming in the child welfare system; service coordination, project coordination, team facilitation, and conflict management.

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 over 50 participants, and consisted of individuals representing consumers as well as a variety of community agencies.

Conferences

Wisconsin Family Ties (WFT) 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. Antionette 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.

The Bureau of Prevention Treatment of Recovery will be hosting its Annual Conference on October 27-28, 2009. The conference theme is "Celebrating Strengths through Challenging Times." Workshops will be provided on topics ranging from Veterans and PTSD to Seclusion and Restraint. Keynote speakers will include: Robert Glover, Ph.D., from NASMHPD, and Rob Morrison, from NASADAD

Psychiatry Teleconferences

Another opportunity for rural providers is the Wisconsin Public Psychiatry Project, which has been operating a bi-weekly teleconference since June of 1995. The 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.
Financial Management: Fiscal Context of Wisconsin Community Mental Health Services

Financial management of public mental health services occurs within the DHS and is overseen by the Division of Enterprise Services (DES) and the Office of Program Initiatives and Budget (OPIB). Within DES are various financial management functions, including accounting, purchasing, and information systems. The Office of Program Initiatives and Budget is responsible for budgeting. DMHSAS negotiates and monitors contracts with the counties and with nonprofit organizations/vendors.

Contracts and Grants Management

Data management within the DES utilizes two stand-alone financial reporting systems with interface capabilities: Wisconsin State Management & Accounting Tool, which is the statewide accounting system; and the Fiscal Management System, which was developed for the DHS; and the Community Aids Reporting System (CARS). The DMT has reporting requirements; and CARS is used to encumber and process payments to the service providers. The three systems have interface capabilities.

Contracts with the counties and nonprofit organizations/vendors are issued annually. General community aids funding is distributed to counties based on formula funding. Factors include
population, per-capita income, and the rural/urban nature of the county. Other funds are contracted to counties and private, non-profit vendors for targeted purposes. The MHBG funds are specifically identified in the contracts for the given services to be provided. Each contract is assigned a contract monitor who establishes the work plan, monitors the contract work plan, and provides assistance to contractors in meeting their contract goals. Contractors are responsible for submitting six-month or annual reports on their progress. A system of peer reviews and site visits for a limited number of contracts annually is also part of contract monitoring plans.

**Fiscal Oversight, Monitoring, and Audits**

Service providers receive a three-month advance at the start of the contract period. They are required to submit expenditure reports (CARS 600 Report) on a monthly basis. These reports are submitted in hard copy format. Client service data is submitted quarterly. Most counties submit the data with monthly online transmittal. Financial data associated with the service data is submitted semiannually. This provides the basis for unit costing analysis. The DMHSAS staff monitors quarterly and semi-annual reports, which provide the basis for identifying and addressing given issues and outcome attainment. Vendors are required to undergo an annual audit from an auditor of their choosing and the results are submitted to DES. The DMHSAS contract monitors work with DES and the contractor when there are audit issues to resolve.

**Revenues and Expenditures for Mental Health**

Medicaid is the largest source of funding for mental health programming. The state GPR funding, along with county tax levy dollars, grant funds (MHBG and PATH) represents 47 percent of the total funding. The state provides funding for a community-based service system. The services for which counties are required to pay the non-federal share include: outpatient mental health for adults in the home or community; crisis intervention; Comprehensive Community Services (CCS); Community Support Programs (CSP); Targeted Case Management; and inpatient hospitalization in the state mental health institutes for individuals under the age of 22 and 65 or older. Many counties in the state allocate county levy tax dollars over the required non-federal share. The state Medicaid non-federal share is approximately 40 percent. Other state and federal Medicaid funds represent amounts not subject to the 60/40 sharing. This may include adjustments/savings from prior year activities and previously allocated inpatient dollars that have been converted to community services due to downsizing the number of institutional beds.

Most importantly, however, is the counties’ contribution to the Wisconsin’s mental health system. Wisconsin has a strong county-based system and the majority of the financial burden of the mental health system falls on counties. In CY 2007, counties contributed a reported $204,551,378 for mental health services. In addition to the Mental Health Block Grant funding, Wisconsin receives other federal funding to support Wisconsin’s mental health service system. The PATH grant of $691,000 to support mental health services for individuals who are homeless in four of Wisconsin’s largest urban areas (responsibility for the PATH program were moved to the Department of Commerce in SFY 2006). An additional $74,000 in state funds were contributed to the four PATH programs which are operated out of the Department of Commerce, Bureau of Supportive Housing. Another $142,200 from a CMHS Data Infrastructure Grant will be used to support the DMHSAS’ capacity for data collection and reporting for the MHBG and other programmatic needs. Wait lists were reduced for CSPs by providing $1,000,000 of state funds for 21 counties. $1,000,000 in GPR is utilized for hospital diversion. Another $1,270,000 of Medicaid funds were used for PASRR Level II screening activities throughout the state. Additionally, $8.8 in GPR is available for IMD relocation and funding for community services.
Wisconsin

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;
Section III - Performance Goals and Action Plans to Improve the Service System

1. Current Activities

   Criterion 5: Management Systems

   Directions: Provides for training of providers of emergency health services regarding mental health.

   Emergency Service Provider Training

Wisconsin’s Emergency and Crisis System

Wisconsin defines crisis intervention as a systematic and organized set of mental health emergency/crisis services and supports provided in the community to individuals and families experiencing heightened emotional distress and/or behavioral disorder. The goal of crisis intervention is to provide alternative and diversionary options to reduce the need for hospitalization and to enhance the community’s crisis response. County crisis programs are certified under Wisconsin Administrative Code DHS 34. Crisis intervention services are dependent upon strong inter-agency coordination and joint training between multiple agencies, i.e., departments of human services, law enforcement, CSP, schools, hospitals, emergency room staff, and private providers. The standards for training are set forth in DHS 34. Crisis program staff training records are maintained locally and are reviewed by the state DHS/Division of Quality Assurance when certifying and re-certifying crisis programs. Currently almost all counties are certified for basic emergency crisis services, and 46 counties are certified under DHS 34 Subchapter III standards for emergency service programs. These programs are eligible for MA or third-party reimbursement.

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 used for the development and/or enhancement of 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 help to sustain the
programs. Of the 35 counties involved in the six Regional Multi-County Crisis Programs, only
two are not certified DHS 34 Subchapter III.

There are six county Human Service Departments that function as fiscal agents for their multi-
county grant: Shawano-Northeast Region; Washburn-Western Region; Marathon-North Central
Region; Washington-Eastern Region; Milwaukee-South Eastern Region; and Ashland-North
Western Region. The population served is children and adults in need of emergency mental
health services. The objectives of the program include:
- Reduce "unnecessary" admissions to hospitals.
- Reduce length of stays at hospitals.
- Divert children and adults to non-hospital community-based options

Each regional grant has a coordinating committee that includes stakeholders pertinent to the goals
of the initiative. Training law enforcement and mental health workers to work together has
improved outcomes. Activities and outcomes that have furthered the objectives of the initiative
include:

- **Milwaukee**--Crisis Intervention Training (CIT) for over 120 Police Officers. This has
  been well received by law enforcement officers.

- **Milwaukee**--Has employed four Peer Support Specialists to serve in their crisis respite
  programs. Peer support has been provided to 530 individuals.

- **Milwaukee**--Opened an eight bed developmentally disabled Crisis Respite Home in
  December, 2006. The four beds budgeted for 2007 have remained full since its opening.

- **Waukesha**--has trained 17 consumers as Peer Support Specialists and five are working
  the Warm Line phone response system. Recipients of peer support indicate that 75
  percent felt they had more control over their lives, 83 percent felt more empowered, and
  72 percent felt their quality of life improved.
• **Waukesha**--is expanding after hours youth crisis services, and developing crisis plans for children in out-of-home care.

• **Western Region**-Burnett, Washburn, Barron, Rusk; with the addition of Buffalo, Chippewa, St. Croix and Dunn Counties who joined over the past two years--
  - Most potential Emergency Detentions (EDs) are able to remain in the community with support.
  - Law enforcement from established counties is helping to train new counties.
  - Crisis is working with L.E. Phillips to serve intoxicated persons that are suicidal.
  - St. Croix County is planning to provide 24 hour mobile response.
  - Dr. Diamond conducted crisis response training for regional crisis staff.

• **Eastern Region (all counties) sponsored "Best Practices in Youth Crisis Prevention and Intervention"**-The region is developing a "Crisis Training Core Curriculum" that will be shared statewide when complete.

• **Eastern Region**-Work group to reduce the number of inpatient admissions and length of stays.

• **Lincoln, Langlade and Marathon**--Continue to divert significant numbers of children and adults from hospitalizations. Need to keep in contact with law enforcement to maintain relationships.

• **Ashland-Iron-Price**--Ashland County has developed a shift-staff foster home as a stabilization option to hospitalization.

• **Washington/Ozaukee County**--
  - Relationship with law enforcement has strengthened resulting in more hospital diversions, reductions in admissions, EDs and length of stays.
  - Washington County has become part of the National Suicide Prevention Network and the America Association of Suicidology.
  - The Bureau Psychiatric Consultant trained law enforcement regarding mental illness and emergency detentions.

From July 1, 2007 through June 30, 2008, grant sites reported that due to their overall effort to provide community-based crisis intervention and stabilization services they were able to divert 967 children and 4,274 adults from inpatient hospitalization. The crisis network supports the DMHSAS initiative to fund collaborative Regional Multi-County Crisis Grants. Each of the five regions has submitted preliminary collaborative crisis development proposals that include all counties in each region. There is much enthusiasm by the DMHSAS Regional Offices and counties for this cooperative approach to funding crisis enhancement grants.

**Crisis Intervention Conference**

The 12th 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, 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. 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
DHS 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 DHS 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 are included in the Adult's section: "Emergency Service Provider Training."
Wisconsin

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
Criterion 5
Grant Expenditure Manner
Criterion 5: Management Systems

Directions: Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

Expenditure Plan for Block Grant Funds for FFY 2010—DRAFT

The Mental Health Block Grant application for FFY 2010 is due to Center for Mental Health Services (CMHS) on September 1, 2009. Although the federal 2010 Budget has not yet been passed by Congress, CMHS has instructed the Division of Mental Health and Substance Abuse Services to assume the same level of funding in FFY 2010, as Wisconsin received in FFY 2009, $7,349,062.

Proposed FFY 2010 MHBG Budget

1) County Formula Allocation (Statutory Cap of $2,513,400) - $2,513,400
This allocation is designated to county mental health agencies to fund programs for persons with serious mental illness. The DHS determines each county agency's MHBG allocation using its standard Community Aids formula. This formula considers each county agency's Medicaid caseload, per capita income, and urban/rural designation. Each agency will use the funds for one or more of the following eight priority areas:

- Certified CSP and/or CCS program development and service delivery
- Supported housing program development and service delivery
- Initiatives to divert persons from jails to mental health services
- Development and expansion of mobile crisis intervention programs
- Consumer peer support and self-help activities
- Coordinated, comprehensive services for children with SED
- Development of strategies and services for persons with co-occurring MH/SA disorders
- Mental health outcome data system improvement

2) Children’s Initiatives - ISP and CST (ISP Capped by Statute at $1,306,700, but not CST) - $1,826,500
The ISP initiative is designed to develop coordinated systems of care for children and adolescents with SED and their families requiring support from multiple community-based agencies. State awards give the county projects the capacity to provide the flexibility needed by both children/adolescents and their families. The CST initiative places an even heavier emphasis on collaboration across child-serving systems. The focus is on creating a “systems change” plan for the county or tribe to establish strength-based systems of care that supports children and adolescents and their families who require substance abuse, mental health, juvenile justice, and/or child welfare services.

3) Family/Consumer Self-Help & Peer-to-Peer Support (By Statute, must allocate no less than $874,000) - $991,629
Wisconsin funds a variety of consumer self-help and peer support programs including programs that work with adult consumers, child consumers, and families of consumers.
4) Transformation Activities *(No Statute)* - $886,033

Per federal focus, Wisconsin will continue to use a portion of the block grant to promote system transformation. Activities include working with State partners, counties, tribes, consumers and advocacy groups to focus on transformation of the county and tribal service systems through start-up grants for CCS/CSP programs and to increase use of evidence-based practices such as Supported Employment. Workforce Development grants will promote solutions for workforce shortages for psychiatric services for children and elders. Workforce Technical Assistance will focus on reducing use of seclusion and restraint and the related need to promote trauma informed care. Tribal State Collaborative funding supports a grant that provides technical assistance and strategic planning support to all tribes to improve each systems delivery of integrated treatment for co-occurring mental health and substance use disorders.

**Detailed Budget Breakout**

- County QI-Continuity of Care: $69,702
- CCS Development/Start-Up: $100,000
- CCS Technical Assistance: $40,240
- Child Welfare Screening: $60,000
- Homeless Access & Outreach to Benefits: $74,000
- Supported Employment: $98,000
- Tribal Best Practices in Co-Occurring Disorder: $100,000
- Workforce Dev. & Psych Consultation: $205,164
- Provider TA to Reduce Seclusion & Promote EBPs: $52,927
- Promote Trauma Informed System: $86,000

5) Systems Change *(By Statute, at least 10% must be for children)* - $222,000

The Systems Change funds will focus heavily on implementing systems change in the areas of improving the current system’s focus on recovery, as well as providing resources for prevention and early intervention and consumer reimbursement as outlined in statutory intent.

**Detailed Budget Breakout**

- Consumer/Family Stipends for Participation: $25,000
- Recovery Coordinator: $82,000
- Prevention/Early Intervention: $95,000
- Youth Suicide Prevention: $20,000

6) Training *(Statutory Cap of $182,000)* - $177,000

Training funds will be contracted to improve provider knowledge and skills in mental health standards, best practice and emergency crisis services for statewide system delivery for consumers of all ages. These funds support the DMHSAS conferences, training for children’s services, statewide teleconferences on clinical topics, and training for schools on promoting positive behavior supports.

**Detailed Budget Breakout**

- Statewide Teleconferences: $87,042
- Annual Conference: $10,000
- Geriatric Psychiatry Training: $5,000
- Children's Program & Crisis Intervention Training: $32,000
Training for Schools - Positive Behavior Supports $22,958
Elderly Initiative $20,000

7) Wisconsin Protection and Advocacy (Statutory Cap of $75,000) - $75,000
Disability Rights Wisconsin is the designated agency within the state to provide protection and advocacy for persons with mental illness.

8) State Operation Costs - $657,500
These funds cover the costs of the staffing for the BPTR, Mental Health Council expenses, accounting, mental health HSRS data expenses, National Outcome Measures reporting and indirect costs of administering the grant.

Total = $7,349,062
Name of Performance Indicator: Increased Access to Services (Number)

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<th>(2) FY 2008 Actual</th>
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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 by one percent annually the number of children served through the public mental health system.

Population: Children with SED and their families.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Number of children ages 0-17 receiving mental health services in FFY 2010.

Measure: Number of children ages 0-17 receiving services through the public mental health system in FFY 2010.

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.

Action Plan: In FFY 2010, 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 $186,900 in program start-up funds. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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, increasing the number of counties that provide CCS benefits will bring services to more children in new areas of the state.

Implementing telehealth (described in Criterion 4) will also provide a vehicle for expanded mental health services in rural parts of the state where these services are currently unavailable. In FFY 2008, Wisconsin had eight sites certified for tele-health. In 2009, there were an additional five counties certified including: Forest, Manitowoc, Marinette, Menominee, and Oconto. Also, 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. This project will build upon existing structure within the
UW-Madison and DHS. DHS will serve as an interface between the local 72 county 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).

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 treatment. The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, but screening primarily for trauma. The new pilot will target five counties in the northeast region of the state.

As Medicaid managed care expands across the state, children are increasingly accessing outpatient and day treatment services through these programs. DMHSAS' data reporting on children served comes from county providers. Medicaid managed care providers report encounter data through the State's MMIS system. This data is being integrated into the State's mental health data warehouse will give a better description of children's access to mental health treatment.
**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

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**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 one percent annually.

**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 2010 who are readmitted within 30 days.

**Measure:**
Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 30 days.
Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010.

**Sources of Information:** 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 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.

**Action Plan:** Wisconsin projects an annual decrease of one-half of one percent in the readmission rate over the FFY 2010 period. While Wisconsin does not have a program initiative specifically targeted at reducing readmission to inpatient hospitals, there are a number of programs that will likely have an impact on this indicator:

*To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) The currently certified counties are: Adams, Brown, Calumet, Dodge, Fond du Lac, Green, Jefferson, Kenosha, Kewaunee, La Crosse, Manitowoc, Menominee, Marathon, Outagamie, Portage, Richland, Sauk, Sheboygan, Washington, Waukesha, Waushara, Winnebago, and Wood. One 2008 start-up funded county (St. Croix) has an application for certification for CCS pending with DQA. Four 2007 and 2008 start-up funded counties have not yet submitted and application or received CCS certification including:
Eau Claire, Marquette, Shawano, and Forest/Vilas/Oneida. Finally, four counties were awarded 2009 start-up funding to develop a CCS program including: Columbia, Iron, Monroe, and Walworth.

*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 committed to funding these multi-county initiatives using state GPR funds from 2006 through 2009. State GPR funds are tentatively committed to continue funding in 2010.

*Additionally, increasing the number of counties that are operating a CST/ISP will reduce the number of out-of-home placements by expanding the availability of wraparound services. Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First are funded through a managed care funding structure. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

*Funding was provided to a small number of county child welfare agencies to implement mental health screening practices to increase the identification and referral of children to mental health treatment. The results of the pilot were mixed. One of the findings of the original pilot was that staff did not appear well informed on the impact of trauma on children and their mental health. In the future, there will be another round of pilots with a modified tool and training. The staff training will likely be on the tool and tool administration, but primarily on trauma. The new pilot will target five counties in the northeast region of the state.

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>21.47</td>
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<td>19</td>
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<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>2,023</td>
<td>2,138</td>
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</tr>
</tbody>
</table>

**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 one percent annually.

**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 2010 who are readmitted within 180 days.

**Measure:**
Numerator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010 who are readmitted within 180 days.
Denominator: The number of children discharged from all state and county psychiatric hospitals in FFY 2010.

**Sources of Information:** 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.

**Action Plan:** Wisconsin projects an annual decrease of one percent in the readmission rate over the FFY
2009-2010 period. While Wisconsin does not have a program initiative specifically targeted at reducing the readmission to inpatient hospitals, there are a number of programs that will likely have an impact on this indicator:

*To date, 27 counties have received Comprehensive Community Services (CSS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) The currently certified counties are: Adams, Brown, Calumet, Dodge, Fond du Lac, Green, Jefferson, Kenosha, Kewaunee, La Crosse, Manitowoc, Menominee, Marathon, Outagamie, Portage, Richland, Sauk, Sheboygan, Washington, Waukesha, Waushara, Winnebago, and Wood. One 2008 start-up funded county (St. Croix) has an application for certification for CCS pending with DQA. Four 2007 and 2008 start-up counties have not yet submitted an application or received CCS certification including: Eau Claire, Marquette, Shawano, and Forest/Vilas/Oneida. Finally, four counties were awarded 2009 start-up funding to develop a CCS program including: Columbia, Iron, Monroe, and Walworth.

*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 committed to funding these multi-county initiatives using state GPR funds from 2006 through 2009. State GPR funds are tentatively committed to continue funding in 2010.

*Finally, increasing the number of counties that are operating a CST/ISP will reduce the number of out-of-home placements by expanding the availability of wraparound services. Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First (CCF) are funded through a managed care funding structure. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and the Lac du Flambeau Tribe.

*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.
**Name of Performance Indicator:** Evidence Based - Number of Practices (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
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<tr>
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</tbody>
</table>

**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 annually.

**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 2010.

**Measure:**
Number of evidence-based practices used for children in the state in FFY 2010.

**Sources of Information:**
Children's mental health program information.

**Special Issues:**
None.

**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.

**Action Plan:**
Wisconsin projects that an additional 29 children, or a total of 2,400 children, will be served through wraparound systems of care in FY 2009; and an additional 30 or a total of 2,430 children, will be served through 2010. The FY 2006 number of children served through wraparound initiatives (2082) reflects the number of children served through Wraparound Milwaukee, Dane County Children Come First (CCF), CSTs and ISPs during that year.

Wisconsin plans to improve its data on the use of evidence-based practices for other initiatives in across the state. In 2007, a survey on EBPs provided through Community Support Programs was implemented and these data are currently being collected for the Uniform Reporting System Data Tables 16-17 (URS Tables). Data from CSPs on the use of evidence-based treatments and other programs can be used not only to complete URS Tables, but also could be used to create an evidence-based practice resource directory for the state.

In FY 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 agencies using evidence-based practices can be used as resource 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.
Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
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</tr>
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<tr>
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<td>N/A</td>
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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 2010.

Population: Children with SED and their families.

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

Indicator: Percentage of children receiving Therapeutic Foster Care in the state in FFY 2010.

Measure: Number of children receiving Therapeutic Foster Care in the state in FFY 2010.

Sources of Information: No current source of data exists.

Special Issues: Wisconsin is currently facilitating the implementation of EBP’s through the provision of grants to 5 counties. A statewide system of data collection for consumers served specifically with EBP’s 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.

Action Plan: 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) for adults. None of the current 5 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 EBP’s for their youth consumers as well.

In addition, the BMHSAS formed an EBP work group in August 2007 to formally define EBP’s and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BMHSAS. A variety of definitions of EBP’s and EBP categorizations exist in the field, including such schemes as 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 EBP’s will help Wisconsin clarify how EBP’s 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...
EBP’s 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.
**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>Denominator</td>
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<td>N/A</td>
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</tbody>
</table>

**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 2010.

**Population:** Children with SED and their families.

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

**Indicator:** Percentage of children receiving Multi-Systemic Therapy in the state in FFY 2010.

**Measure:** Number of children receiving Multi-Systemic Therapy in the state in FFY 2010.

**Sources of Information:** No current data source exists.

**Special Issues:** Wisconsin is currently facilitating the implementation of EBP’s through the provision of grants to 5 counties. A statewide system of data collection for consumers served specifically with EBP’s 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.

**Action Plan:**

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) for adults. None of the current 5 counties chose to implement Multi-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 EBP’s for their youth consumers as well.

In addition, the BMHSAS formed an EBP work group in August 2007 to formally define EBP’s and to help coordinate the various EBP efforts across the mental health and substance abuse areas within the BMHSAS. A variety of definitions of EBP’s and EBP categorizations exist in the field, including such schemes as 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 EBP’s 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 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 EBP’s 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.
**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
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</thead>
<tbody>
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<td>Performance Indicator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

**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 2010.

**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 2010.

**Measure:** Percentage of children receiving Family Functional Therapy in the state in FFY 2010.

**Sources of Information:** No current data source exists.

**Special Issues:** Wisconsin is currently facilitating the implementation of EBP’s through the provision of grants to 5 counties. A statewide system of data collection for consumers served specifically with EBP’s 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.

**Action Plan:** 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) for adults. None of the current 5 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 EBP’s for their youth consumers as well.

In addition, the BPTR formed an EBP work group in August 2007 to formally define EBP’s 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 such schemes as 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 EBP’s will help Wisconsin clarify how EBP’s 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 EBP’s 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.
**CHILD - GOALS TARGETS AND ACTION PLANS**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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<tr>
<td>Performance Indicator</td>
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<td>Denominator</td>
<td>332</td>
<td>338</td>
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</tr>
</tbody>
</table>

**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 FY 2010.
- Denominator: The total number of parents or guardians responding to the youth survey in FY 2010.

**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.

**Action Plan:** Wisconsin collects consumer satisfaction data using the Mental Health Statistical Improvement Program's (MHSIP) adult and youth consumer satisfaction surveys. To assess satisfaction with children's services, the Bureau administers the MHSIP Youth Services Survey to a parent or guardian of the youth. The Mental Health Data Infrastructure Grant (DIG) is annually budgeted to fund the administration of the satisfaction surveys.

In FFY 2009, Wisconsin will analyze the data from the MHSIP to ascertain which services have the lowest scores for satisfaction, and the reasons for the low satisfaction with these services. In FFY 2009, 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, mechanisms have been developed to collect outcome data and quality indicators and the way in which success of services and supports are provided will be modified. A MH/SA Functional Screen was developed, in part, for local agencies to utilize in the development of indicators for data driven quality improvement. Wisconsin is also 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 began in five pilot counties and is now utilized in approximately 40 counties. In participating counties, baseline ROSI data were collected in 2009 and a round of one-year follow up ROSI surveys will be implemented in 2010 to measure potential change in the use of recovery principles.
Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
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<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
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<td>231</td>
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</tr>
</tbody>
</table>

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 2010 since starting mental health services.

Measure: Numerator: Number of children 6-18 years old with SED whose school attendance has increased in FFY 2010 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 2010.

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.

Action Plan: Wisconsin projects an annual increase of three percent in the increased school attendance rate.
over the FFY 2010 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 55 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 ISP, CST, and CCS programs also provide supports and services to enable children with SED to avoid entering the juvenile justice system or other restrictive environments.

*In 2007, 15 ISPs, 22 CSTs and 6 projects that received both ISP and CST funding existed throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First are funded through a managed care funding structure. In FFY 2008, eight CST counties or tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. In FFY 2009, six CST counties or tribes will be added: Sawyer, Wood Clark, Green, Oconto, Kewaunee, Bad River Tribe, Lac du Flambeau Tribe. T

*The CCS benefit will expand the availability of outpatient MA-funded mental health services. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 is educating additional counties to do the same in FFY 2009.

*To improve data collection, Wisconsin's current web-based data system is being updated to interface with the HSARS system and will include a module that collects juvenile justice recidivism rates for children with SED served through ISP, CST, and CCS projects.
**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
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<td>Fiscal Year</td>
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<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
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<td>Performance Indicator</td>
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<td>Denominator</td>
<td>75</td>
<td>60</td>
<td>--</td>
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</tr>
</tbody>
</table>

**Transformation Activities:**

**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 2010 after being arrested in FFY 2009.

**Measure:**
Numerator: Number of youth 6-18 years old with SED who were arrested again in FFY 2010 after being arrested in FFY 2009.
Denominator: Number of youth 6-18 years old with SED who were arrested in FFY 2009.

**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. For this indicator, parents/guardians describe if their child was arrested in either FFY 2009 or FFY 2010. The indicator focuses on children arrested in FFY 2009 to see if they were able to avoid being arrested again in FFY 2010.

**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.

**Action Plan:** Wisconsin projects an annual decrease of three percent in the juvenile justice system recidivism
rate over the FFY 2010 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 55 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 ISP, CST, and CCS programs also provide supports and services to enable children with SED to avoid entering the juvenile justice system or other restrictive environments.

*In 2007, 15 ISPs, 22 CSTs and six projects that received both ISP and CST funding existed throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First are funded through a managed care funding structure. In FFY 2008, eight CST counties or tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. In FFY 2009, six CST counties or tribes will be added: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

*The CCS benefit will expand the availability of outpatient MA-funded mental health services. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 are educating additional counties to do the same in FFY 2009.

*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.
**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
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<tr>
<td></td>
<td>FY 2007 Actual</td>
<td>1,874</td>
<td>3,498</td>
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<td></td>
<td>FY 2008 Actual</td>
<td>1,907</td>
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</tr>
<tr>
<td></td>
<td>FY 2011 Target</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**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 2010.

**Measure:**

- **Numerator:** Number of children 0-17 years old with SED in an unstable living situation in FFY 2010.
- **Denominator:** Number of children 0-17 years old with SED receiving services through the public mental health system in FFY 2010 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.

**Action Plan:**

Wisconsin projects an annual decrease of one percent in unstable housing situations over the FFY 2010 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 55 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 ISP, CST, and CCS programs also provide supports and services to enable children with SED to living in the least restrictive environment.

*Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come...*
First (CCF) are funded through a managed care funding structure. In FFY 2208, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

*The CCS benefit will expand the availability of outpatient MA-funded mental health services. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 is educating additional counties to do the same in FFY 2009.

*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 stability in housing for children with SED served through ISP, CST, and CCS projects.
**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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<tr>
<td>Performance Indicator</td>
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<td>Numerator</td>
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</tr>
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<td>Denominator</td>
<td>334</td>
<td>339</td>
<td>--</td>
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</tr>
</tbody>
</table>

**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 2010.

**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 2010.

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 2010.

**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.

**Action Plan:** Wisconsin projects an annual increase of one percent in the rate of social connectedness for
children with SED over the FFY 2010 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 55 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. 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. These programs create a system of care which helps children with SED and their families develop a network of natural/social supports.

Other wraparound and integrated services projects across the state including ISP, CST, and CCS programs also provide a system of care that helps children with SED and their families develop a wraparound team including natural supports.

*Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First (CCF) are funded through a managed care funding structure. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilees, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

*The CCS benefit will expand the availability of outpatient MA-funded mental health services. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 is educating additional counties to do the same in FFY 2009.

*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 social connectedness rates for children with SED served through ISP, CST, and CCS projects.
**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
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<td>Denominator</td>
<td>332</td>
<td>338</td>
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</tr>
</tbody>
</table>

**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 2010.

**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 2010.
- **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 2010.

**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.

**Action Plan:** Wisconsin projects an annual increase of three percent in the level of functioning rate over the
FFY 2010 period. 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.

Wraparound and integrated services projects across the state including ISP, CST, and CCS programs provide supports and services to enable children with SED to improve their level of functioning.

*Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First (CCF) are funded through a managed care funding structure. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

*The CCS benefit will expand the availability of outpatient MA-funded mental health services. To date, 27 counties have received Comprehensive Community Services (CCS) certification through the Division of Quality Assurance (DQA). (Milwaukee decided not to operate a CCS program after they were certified.) 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 is educating additional counties to do the same in FFY 2009.

*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 rates of improved functioning for children with SED served through ISP, CST, and CCS projects.
Name of Performance Indicator: Improve access to telehealth consultation in rural areas.

Transformation Activities: ☐

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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<tr>
<td>Denominator</td>
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</tbody>
</table>

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.

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 for FFY 2010.

Measure: The number of rural counties with certified tele-health systems in place to serve children in FFY 2010.

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.

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.

Action Plan: 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 will allow more children to take advantage of the services and thereby make providers more willing 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. In FFY 2006, four new sites were certified including Trempeleau and Adams Counties, as well as two more Marshfield satellite clinics in Rusk and Oneida Counties. In FFY 2007, Kewaunee and Iron Counties added certified telehealth services. Although additional telehealth programs become certified every year, the lack of funding for acquiring telehealth equipment is still a barrier for some providers. To address this, the Division of Health Care Financing (DHCF - the State Medicaid agency) 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 certified eight additional sites for tele-health; and 2009, five more counties were certified including: Forest, Manitowoc, Marinette, Menominee, and Oconto.
Name of Performance Indicator: Number of Children Receiving Evidence-based Practices

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
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<td>FY 2008 Actual</td>
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<tr>
<td>FY 2009 Projected</td>
<td>2,400</td>
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<td>FY 2010 Target</td>
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<td>FY 2011 Target</td>
<td>2,460</td>
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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 2010.

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 2010.

Measure: Number of children receiving evidence-based practices in the state in FFY 2010.

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.

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.

Action Plan: Wisconsin projects that an additional 29 children, or a total of 2,400 children, will be served through wraparound systems of care in FFY 2009; and an additional 30 children, or a total of 2,430 children, will be served through 2010. The number of children served through wraparound initiatives each year reflects the number of children served through Wraparound Milwaukee, Dane County Children Come First (CCF), CSTs and ISPs during that year.

Wisconsin plans to improve its data on the use of evidence-based practice 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, 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 resource 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.
Name of Performance Indicator: System organization training.

Table Descriptors:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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<tbody>
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<td>Performance Indicator</td>
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<td>77</td>
<td>80</td>
<td>83</td>
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<td>Numerator</td>
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<td>Denominator</td>
<td>72</td>
<td>72</td>
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</tr>
</tbody>
</table>

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 two the number of counties with children’s service staff trained in organizing collaborative service delivery systems within the wraparound programs for FFY 2010.

Population: Children with SED and their families.

Criterion: 5: Management Systems

Indicator: Number of counties with mental health and other children’s service agency staff trained in organizing wraparound programs annually in FFY 2010.

Measure: Numerator: Number of counties with mental health and other children’s service agency staff trained in organizing wraparound programs in FFY 2010. Denominator: Number of counties in Wisconsin in FFY 2010.

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.

Action Plan: Similar to Criterion 1, 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 are based on 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. Currently, 15 ISPs, 22 CSTs and six projects that receive both ISP and CST funding exist throughout the state. Additionally, Wraparound Milwaukee and Dane County Children Come First (CCF) are funded through a managed care funding structure. In FFY 2008, six counties and two tribes were added: Ashland, Burnett, Lac Courte Oreilles, Red Cliff, Menominee, Price, Monroe, and Juneau. Six counties and two tribes will be added in FFY 2009: Sawyer, Wood, Clark, Green, Oconto, Kewaunee, Bad River Tribe, and Lac du Flambeau Tribe.

Wisconsin will continue to use funding from multiple sources to fund the new CSTs. In addition, Wisconsin will explore the possibility of providing support in the form of technical assistance and training to additional counties which will allow them to start a CST program in the absence of additional funding from the state.
Name of Performance Indicator: Wraparound Services

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<th>Numerator</th>
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<td>FY 2008 Actual</td>
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<td>FY 2009 Projected</td>
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</tr>
<tr>
<td>FY 2011 Target</td>
<td>77</td>
<td>--</td>
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Table Descriptors:
- **Goal:** To expand wraparound services to all counties.
- **Target:** To annually increase by two the number of counties with initiatives using the wraparound model annually.
- **Population:** Children with SED and their families.
- **Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- **Indicator:** Percentage of counties with wraparound initiatives.
- **Measure:** Numerator: Number of counties with wraparound initiatives in FFY 2010. Denominator: Number of counties in Wisconsin.
- **Sources of Information:** Department funding information for wraparound programs.
- **Special Issues:** The ultimate goal for Wisconsin is to expand integrated service programs using a wraparound approach in all counties statewide. Thus, to best reflect progress towards that goal, the indicator is stated as the percentage of all counties because it illustrates state coverage more effectively than the number of all counties. Not all county programs serving children are funded through the Mental Health Block Grant. The two largest counties sustain their children’s wraparound initiatives solely through Medicaid and county funds (see the performance indicator table for details). All of these county programs are included in this performance indicator.
- **Significance:** The expansion of wraparound service programming for children is one of the top priorities of Wisconsin’s Mental Health Council and the DMHSAS.
- **Action Plan:** In FFY 2006, Wisconsin added one additional CST. Starting July 1, 2006, Brown County was funded to develop and operate a CST program using state GPR funds. As we have in the past, Wisconsin will continue to use funding from multiple sources to fund the new CSTs. In addition, we will explore the possibility of providing support in the form of technical assistance and training to additional counties which will allow them to start a CST program in the absence of additional funding from the state.

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; and the Lac Corte 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 a CST without a full implementation grant, but they do receive some limited training and technical assistance funding.
Wisconsin

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan
August 24, 2009

Ms. Barbara Orlando, Grants Manager Specialist
Division of Grants Management, OPS
Room 7-1091
SAMHSA
1 Choke Cherry Road,
Rockville, Maryland 20857

Dear Ms. Orlando:

The Wisconsin Council on Mental Health is the statutory mental health planning council for the State of Wisconsin. In order to meet the Council’s obligation to review and provide comment on the proposed plan, it formed two committees to review the Adult and Children’s Mental Health Plans. The committees met separately with the State Planner on June 25, 2009. Input from the Committees was incorporated into the draft Plan and reviewed by Council at its meeting on July 15, 2009.

The Council met for its review and made final recommendations with respect to the FFY 2010 Community Mental Health Block Grant application in compliance with section 1915(a)(2) of Public law 102-231. Members of the public were also invited to comment. The Council reviewed comments made by MHC sub-committees, as well as individuals at the public hearing, and considered the Department's responses in our decision to support submission of the Plan.

The Bureau of Prevention, Treatment, and Recovery (BPTR), within the Division of Mental Health and Substance Abuse Services, is responsible for development of the State Plan and supporting the Council. The Bureau’s Planner, just finishing her third year, continues to demonstrate a strong desire to work with the Council in developing and reviewing the plan. Council members requested to have the draft plan earlier than in past years. Although the plan was not sent out to the Council as early as requested, hard copies of the draft plan were sent to all Council members two weeks before the MHC sub-committee meetings. This process allowed the committees to review the plan in depth and report back to the full Council. The plan was also posted on the MHC website for public review a week before the public hearing, however the online web format made it cumbersome to print.

The state is making progress toward improving data on mental health services. However, Council members remain concerned about the ineffectiveness of some State Plan indicators as measures of state progress toward meeting important mental health goals and objectives. Council members are also concerned about the quality and sources of data collected by the Department of Health Services (DHS). These concerns are particularly acute with respect to data reported on services by counties that are utilized for policy development.
Other areas of Council concern include:

- Adequacy of programs for youth with emotional or behavioral disorders in transition, including whether peer-to-peer programming should be tried;
- Difficulty obtaining needed services, including services for families who have children not yet identified as having mental health issues;
- Adequacy of the network of mental health services providers, which contributes to difficulty in obtaining services for both adults and children;
- Mental Health providers, especially psychiatrists, are frequently not available in many areas of the state. This shortage is worsening each year:
  o The provider shortage is most acute with respect to “specialty populations,” e.g. children/youth, older adults or deaf and rural/urban core areas;
  o Several of the state’s most effective program initiatives, including “wraparound,” are available only in certain counties of the state despite need in every county;
  o Access to other initiatives, including crisis, suicide and bullying prevention programs, is severely limited in many parts of the state; and
  o Access to dentistry is severely limited for consumers in much of the State.
- Where programs exist, improvement is often necessary:
  o Community Support Programs often do not fully implement the PACT model; and
  o Follow-up to emergency services is often missing.

Additional areas of Council concern include:

- Lack of service availability leads to hospitalization demonstrated by high readmission rates, more restrictive environments, jail and homelessness;
- Wisconsin’s Department of Health Services (DHS) has been diligently working on policy that limits the use of isolation, seclusion and restraint, however, members are especially concerned with use of these procedures in schools;
- Now that the State does a better job of identifying the high degree of prevalence of mental illness among long-term care consumers, quality services provided by competent professionals need to be available more consistently;
- Services Aging and Disability Resource Centers are supposed to provide are sometimes not available to mental health consumers;
- The relocation waiver program for mental health consumers has not been fully implemented. This is part of successor program, the Self Directed Services waiver, and has more limited service package;
- Wisconsin lacks parity for mental health and substance abuse coverage.
- The MHBG Plan states that initiatives such as “tele-health” and the MH/SA functional screen address service shortages without supporting data; and
- The mental health needs of returning veterans are not adequately addressed in Wisconsin.

We understand that most of these concerns have been addressed in the final version of the plan. To the extent that they have not been addressed in the FFY 2010 plan, we will continue to work to see that they are addressed in future plans.
In summary, the Council is pleased to endorse the State Plan application for 2010, and appreciates the opportunity to comment. We look forward to working with the Department and others in State Government to address the many areas of continuing need.

Very truly yours,

Jackie Baldwin, Chair
Wisconsin Council on Mental Health

cc: Wisconsin Council on Mental Health membership
Karen Timberlake, Secretary, Wisconsin Department of Health Services
John Easterday, Administrator, Division of Mental Health and Substance Abuse Services
Joyce Allen, Director, Bureau of Prevention, Treatment and Recovery
Melanie Foxcroft, Council Staff
Peg Algar, Planner
Wisconsin

Appendix A (Optional)

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.