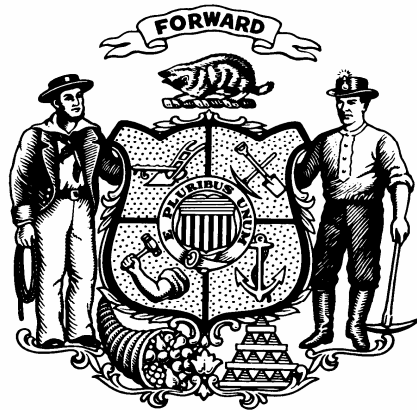


SECTION III - PART A:

**WISCONSIN'S
ADULT MENTAL HEALTH PLAN**

FEDERAL FISCAL YEARS 2008-2009



Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Wisconsin's Transformation Planning

Wisconsin has traditionally been a national leader in the development of services for persons with mental illness. The Division of Mental Health and Substance Abuse Services, together with its traditional partners in mental health services, the Wisconsin Counties, have begun a journey of transformation together. Because of limited funding, the initial focus is on transformation of those services for adults with serious mental illness and children with serious emotional disturbance.

Transformation Activities

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 braid 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.

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 year 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. The transformation efforts also include the fostering of evidence based practices in pilot counties, (currently 5 counties are participating), 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.

The development of a quality improvement tool called the Recovery Oriented System Assessment (ROSA) was tested and finalized for redesign. Although this tool has not implemented as yet for measurement of outcomes at the local level, because of the cost of implementation, the tool itself is being used by many counties to check against their existing assessments and planning processes to ensure a recovery emphasis is in place. A Mental Health/Substance Abuse Functional Screen (MH/SA) was developed through the Redesign initiative 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 state wide. The screen is now being used in 41 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. This tool is linked to similar web based screens for children and for adults that determine eligibility for the Wisconsin community based long term care system. The screens can be transferred from program to program and contain links to each other so it cues the screener to test for long term care eligibility. This ensures that no program eligibility is overlooked for individuals seeking services and supports. The screens can also be used for system planning at the local level as it can provide aggregate information on the array of physical conditions, and service and support needs and intensity for a population that has mental health issues. As the state can access the same data in real time they can help local agencies with assessment of need and program development by assisting with the analysis of the needs of the population being served at the local level.

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. The allocation of some of the Mental Health Block Grant (MHBG) funds will be dedicated to the analysis and reporting of data from these two tools.

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 will be 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 2007 with the option of being renewed in 2008.

The transformation activities described above address: Goal 2, Recommendation 2.2; Goal 4, Recommendations 4.3 and 4.4; Goal 5, Recommendations 5.1 and 5.2; and Goal 6, Recommendation 6.2 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.

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 mental illnesses.

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

Goal 6--Technology is used to access mental health care and information.

Recommendation 6.2--Develop and implement integrated electronic health record and personal health information systems.

the Wisconsin Council on Mental Health and guidance from the Governor’s Office. 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. In May of 2007 the 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 mental health population, increasing stability in housing and increasing or retaining employment and or education for the mental health population. In 2008 MHBG funds will be set aside to form a strategic planning group to create a focused plan for transformation that is realistic and within the resources that are available at the state and with our partnering counties.

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 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 and Family Services (DHFS) 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 (May 2007)**

Number of Programs	Program Area	Regulated by:
44	Inpatient	HFS 61.70 – 61.72
23	Emergency Service 2	HFS 34 Sub II
40	Emergency Service 3	HFS 34 Sub III
26	Day Treatment	HFS 61.75
16	Adolescent Inpatient	HFS 61.79
35	Day Treatment Services for Children 1	HFS 40 Level I
10	Day Treatment Services for Children 2	HFS 40 Level II
7	Day Treatment Services for Children 3	HFS 40 Level III
842	Outpatient	HFS 61.91 – 61.98
80	Community Support Programs (ACT)	HFS 63
20	Comprehensive Community Services	HFS 36

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 elders, the deaf and hard of hearing population, the homeless and individuals with both mental health and physical conditions requiring treatment and support.

Prevention and Early Intervention

The Mental Health Association (MHA) in Wisconsin

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

The above activities address Goal 1, Recommendations 1.1 and 1.2; and Goal 4, Recommendations 4.2 and 4.4 of the President's Freedom Commission on Mental Health:

Goal 1--Americans understand that mental health is essential to overall health.

Recommendation 1.1--Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

Recommendation 1.2--Address mental health with the same urgency as physical health.

Goal 4--Early mental health screening, assessment, and referral to service are common practice.

Recommendation 4.2--Improve and expand school mental health programs.

Recommendation 4.4--Screen for mental disorders in the primary health care, across the life span, and connect to treatment and supports.

Task Force on Women and Depression

Lieutenant Governor Barbara Lawton commissioned a Task Force on Women and Depression in Wisconsin, which released its report in May 2006. Currently, an Implementation Committee for the Report has been convened to identify specific activities which will and are addressing Report recommendations. Experts, professionals, state staff, legislators, consumer and family members are meeting in several committees, which report back to the larger group on progress from academia, state government, advocacy groups, public and private practice mental health systems regarding strategies for:

- collection of available data on the extent of the problem of depression among Wisconsin women,
- review of the available science on the causes of depression among women,
- review of the scientific evidence on effective best practice and evidence-based treatment and prevention/early intervention programs, and
- identifying policies that would reduce problem related issues of depression for women in Wisconsin.

This Task Force and its work is believed to be unique and progressive within the U.S., which is linking mental health issues, research, and public policy to the corrections system, violence against women and other areas often held apart as discrete categories.

Task Force on Perinatal Depression

The Wisconsin Task Force on Perinatal Depression is a dedicated statewide partnership working to promote the mental health of women, their infants, and families. The Task Force is striving to increase public awareness, understanding and knowledge of depression during pregnancy and the postpartum period, the impact of unidentified and untreated depression, the importance of preventive interventions, effective treatments, resources, and recovery. The Task Force promotes strategies for screening, comprehensive evaluation, referral, and access to treatments supports and resources that contribute towards recovery. The Task Force promotes, as a public priority increased awareness of maternal/infant and family mental health issues, and offers effective, evidenced-based practices and policies. These policies will promote the mental health of women, their infants, and families. Members of the Task Force bring together expertise, resources, and consumers across varied systems from nursing, public health, mental health, therapists and other health care providers, the University of Wisconsin Postpartum Depression program, the Lt. Governor's Task Force on Women and Depression, and insurance providers. The speaker's bureau of the Task Force has given numerous presentations statewide and nationally. The work of the Task Force impacts health outcomes for women and their families through increased access, comprehensive screening/ assessment, evaluation, and referral to best practice or evidence-based treatment.

Aging and Disability Resource Centers

Wisconsin is investing heavily in Aging and Disability Resource Centers (ADRC), which offer the general public a single entry point for information and assistance on issues affecting older people and people with disabilities (including mental illness), or their families. There are eighteen ADRCs currently operating including two regional ADRCs for rural areas (serving 3 counties each). ADRCs are required by contract to provide three services to persons with mental illness: information and assistance, emergency response and the services of a disability benefit specialist. The Division of Mental Health and Substance Abuse Services 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 has produced three training web-casts in 2007 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 ensure ADRC staff understood the functional eligibility for Wisconsin Mental Health programs and how to access them through referrals to their local mental health agencies.

The above activities address Goal 1, Recommendation 1.1 and 1.2; Goal 4, Recommendation 4.3 and 4.4; and Goal 5, Recommendation 5.2 of the President's Freedom Commission on Mental Health:

Goal 1--Americans understand that mental health is essential of overall health.

Recommendation 1.1--Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

Recommendation 1.2--Address mental health with the same urgency as physical health.

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

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 840 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. Work is continuing to revise the Administrative Rule for Outpatient Mental Health Services to bring it up-to-date.

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 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 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 HFS 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 2007 there were 80 CSPs in Wisconsin (see map, below) which meet the standards for CSP certification established by the Department of Health and Family Services. In CY 2005, CSPs served 5,624 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 mental illness.

Targeted Case Management

Targeted case management is a mechanism for coordinating and arranging services. It includes, but is not limited to, 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 Financing 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 broader group of consumers and an array of mental health rehabilitation services available in each county that are appropriate to their needs. The administrative rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to children and adults and elders whose psychosocial needs require more than outpatient therapy, but less than the level of services provided by CSPs. 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.

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. Twenty counties have been certified since the Comprehensive Community Services (CCS) rule went into effect including: Brown, Calumet, Fond du Lac, Green Lake, La Crosse, Jefferson, Kenosha, Manitowoc, Milwaukee, Marathon, Outagamie, Portage, Sauk, Richland, Sheboygan, Washington, Waukesha, Waushara, Winnebago and Wood counties. Some examples of service delivery development in which counties can engage include: local systems change to provide for the set up of a coordinating committee with the 51% consumer requirement of the CCS rule; development of a service array to provide comprehensive services across the lifespan; development or revision of assessment; and care plan processes to ensure they are strength based and staff training in recovery principles and consumer focused outcomes. Eau Claire, Menominee, Kewaunee have startup funds and are expected to submit applications by the end of 2007. Waupaca, Dodge, and Iowa-Grant (a two-county application) have submitted their applications and certification approval has not yet been given to them.

Community Support Programs, the ACT model and CCS address Goal 2, Recommendation 2.1; Goal 4, Recommendation 4.4; and Goal 5, Recommendations 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 mental illness and child with a serious emotional disturbance.

Goal 4--Early mental health screening assessment, and referral to services are common practice.

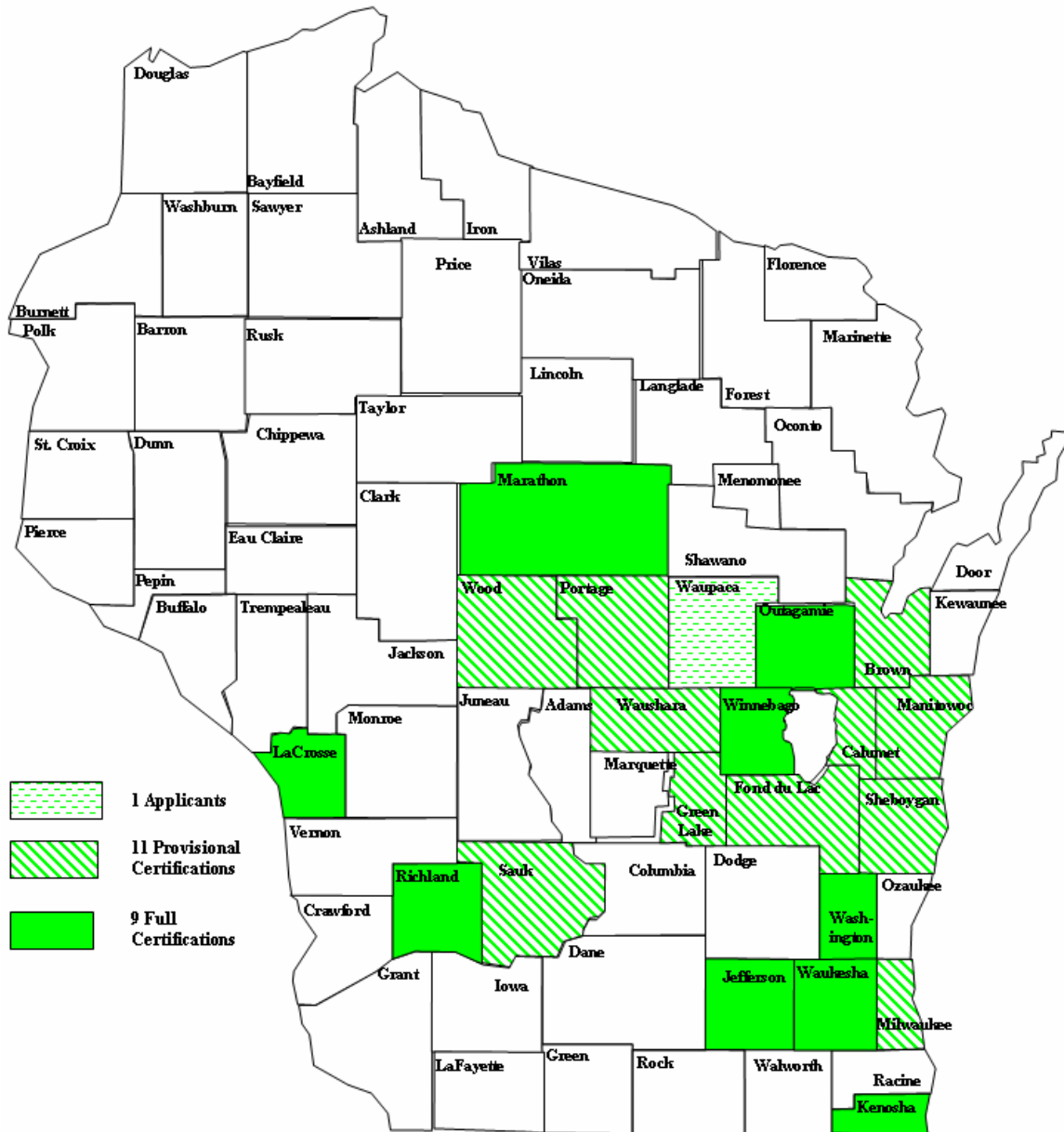
Recommendation 4.4--Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

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 mental illnesses.

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

COMPREHENSIVE COMMUNITY SERVICES (CCS) PROGRAMS
(April 2007)



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 2005, the COP served a total of 27,222 persons across the state including 1,133 persons with a serious mental illness, or 6.5% of the total population served through COP. This is an increase from 2004, in which COP served 26,923 persons of which 3 percent had a serious mental illness. The increase can be attributed in part to an aggressive promotion of COP as a funding source for SMI by DMHSAS and the use of the mental health functional screen instead of prior requirements. The increase has almost achieved the minimum percentage of 6.6% state wide for the mental health population, a target for serving the SMI in COP set by the state in 1982. A total of \$10,809,427 was spent on the SMI population in 2005. It should be noted that this only represents 2% of the total state wide COP budget.

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 mental illness is the Pre-admission Screening and Resident Review (PASRR) process. As with hospitals, the cost of care and treatment of persons ages 22 to 65 who are in a nursing facility that has been identified as an Institute for Mental Disease (IMD) is borne by the county. However, the county may recover the cost of care and treatment from the person, which may include insurance payments for mental health treatment.

In 2005, the contracted PASRR agency completed 6,093 screens for persons who have a mental illness. Twenty-three (0.4 percent) of the persons screened were determined not to need nursing facility placement and 471 (7.7 percent) of the persons screened were found to need specialized psychiatric rehabilitation services. Eighty-one percent of these screens were for persons ages 65 and older and 69.9 percent of these screens found that the person has a severe medical condition or severe cognitive losses. In 2006 the contracted PASRR agency completed 6,271 screens for persons who have a 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. Eighty-one point eight percent of the screens were for persons ages 65 and older and 71.4 percent of the screens found that the person has a severe medical condition or severe cognitive losses. During both 2005 and 2006, 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 inpatient psychiatric hospitalization; although 2 persons in 2005 and 1 person in 2006 were prohibited from being admitted due to a specialized services determination.

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

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.

As stated above, the Department submitted an application for a Homeland Community-Based Waiver (HCBW) called Community Options in Recovery (COR) for persons who have a 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 would be 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 CMS and DMHSAS expects to enroll the first individuals in this new relocation waiver in September of 2007. 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 would also include mental health community services such as counseling and therapeutic resources, observation-supervision, peer supports, daily living skills, and job skills training, natural/family supports education and training, and transportation. Eligibility will be based on nursing home eligibility, a diagnosis of 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.

In addition to completing and submitting the waiver, the Department has been focusing on developing mechanisms to assess and plan for relocation of individuals without the waiver in place. Working arrangements among county and nursing home staff, consumer and advocacy groups, and providers of care will be needed to identify systems that safely provide care to individuals placed in the community. CCS as a psycho-social rehabilitation service across the lifespan is a critical element in these relocations where the person fails to qualify for the COR waiver.

Institutional and Inpatient Services

The Wisconsin public mental health system recognizes the need for people with serious and persistent 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. The 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 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:
Wisconsin Hospitals - Average¹ Length of Stay (LOS)
(Calendar Years 1996 – 2005)**

Payer	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Medicare	13.00	13.26	12.02	12.04	12.55	12.49	11.87	12.29	12.41	11.22
Medicaid	16.05	15.88	15.99	13.65	12.18	11.25	9.94	9.62	9.37	8.11
Other Govt.	31.41	30.25	29.60	8.91	6.97	5.73	5.91	5.85	5.97	5.51
Private Ins.	6.78	6.73	6.75	8.50	8.22	8.81	10.04	7.97	6.15	6.66
Self Pay	10.21	8.95	8.31	27.65	24.17	16.20	16.94	19.81	33.89	21.15
Other/Unknown	5.78	5.15	N/A	9.45	5.86	42.75	8.02	26.49	30.17	6.60
TOTAL LOS	12.32	12.15	11.74	11.82	11.24	10.70	10.75	10.39	11.25	9.47

Source: April 2007 – Bureau of Health Information, Division of Health Care Financing

1 - The total average length of stay cannot be computed by averaging each column of figures due to variance in the number of people in each category.

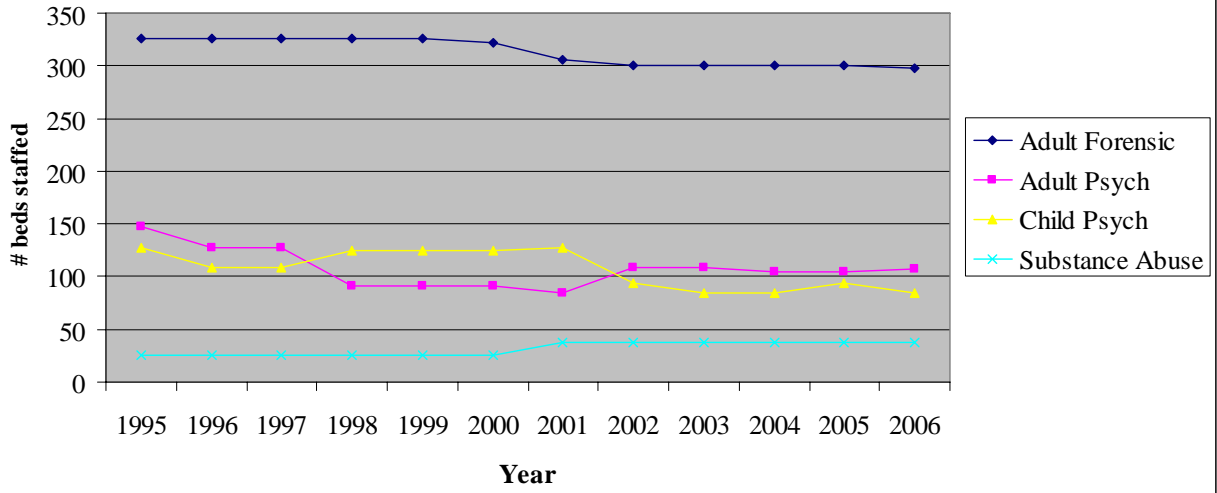
While generalizations must be taken with caution, from the standpoint of the Major Diagnostic Category of mental diseases and disorders, the data trend generally portrays a sustained drop in the average length of stay from throughout the ten-year period. While restrictions in dollars can easily be used as an argument to explain this trend, it does not account for the recidivism that would be the inevitable result if there were lack of community services available after initial hospital discharge.

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 10 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 10) 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 10 does not indicate a significant reduction in the use of state-owned hospital beds, although the utilization rate is low for a state population of over 5.5 million persons. This is because there has been a decrease in private general psychiatric beds throughout Wisconsin causing inpatient bed shortages due to current economic short falls, staff reallocations, and shortages in the workforce. Other challenges center around the point at which the reduction of inpatient psychiatric beds becomes a negative factor on the ability of a comprehensive community-based system to provide timely and age appropriate access to consumers across the life span. A delay in access to inpatient services can mean that the severity and duration of the illness may be increased, a longer hospital stay is required, and there is greater demand for specialized mental health services, medications and other health care treatment.

**Chart 1:
Staffed Beds at State-operated Psychiatric Hospitals 1995 - 2006**



**Chart 2:
Average Daily Census at State-operated Psychiatric Hospitals 1995 to 2006**

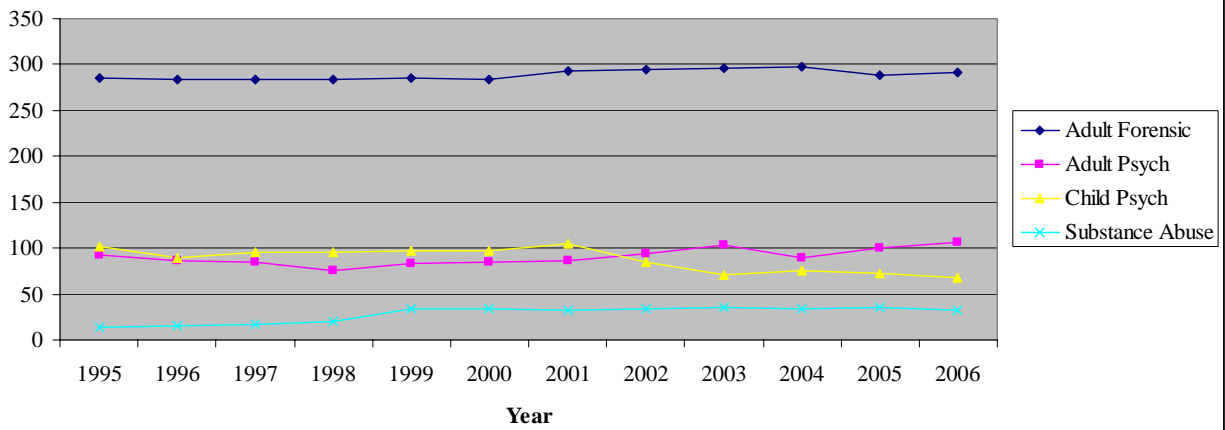


Table 10:
State-operated Psychiatric Inpatient Hospital Utilization (Average Daily Census)
 (State Fiscal Year 1995-2006)

State Psychiatric Inpatient Hospital Beds (staffed) – State Fiscal Year 1995-2006												
Bed Type	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Adult Forensic	326	326	326	326	326	322	306	301	301	301	301	298
Adult Psych	147	127	127	91	91	91	85	109	109	105	104	107
Child Psych	127	109	109	125	125	125	127	94	84	84	94	84
Substance Abuse	25	25	25	25	25	25	37	37	37	37	37	37
Total	625	587	587	563	563	563	555	541	531	527	536	526

State Psychiatric Inpatient Hospital Utilization (Average Daily Census) – State Fiscal Year 1995-2006												
Bed Type	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Adult Forensic	286	284	283	283	285	283.1	293.1	294.6	296	298.3	288	290.8
Adult Psych	92	86	85	75	84	84.3	86.4	93.4	103	89.9	99.7	106.6
Child Psych	101	89	95	96	97	97.1	104.7	85.5	70.6	75.2	71.9	67.1
Substance Abuse	14	15	17	20	34	33.7	32.6	33.4	35.0	34.5	34.9	32.8
Total	493	474	480	484	500	498.2	516.8	506.9	504.6	497.9	494.5	497.3

Source: DMHSAS (2006)

Other Services to Promote Recovery

Recovery

In FFY 2007, \$13,000 was awarded to NAMI Wisconsin to continue their core Recovery activities including web domain development and maintenance, a Recovery newsletter (3 issues per year), consumer summits (2 per year) and some personnel costs. Another \$65,000 was contracted to the University of Wisconsin Psychiatry Department for a full-time Outreach Specialist position to provide technical assistance to consumers, counties / tribes, and providers around issues of Recovery in CCS and CSP. This person is dedicated to coordinating and disseminating recovery information in statewide system transformation efforts. This person is also responsible for working with DMHSAS and its partners statewide to be a central point for technical assistance and training issues around the recovery model. The Recovery Implementation Task Force, NAMI, Grassroots Empowerment Project, Wisconsin Family Ties, and other key stakeholders partner with this position to keep recovery information current and relevant to the citizens of the state of Wisconsin. The position works with partner consumers who are the primary presenters for all presentations and trainings as well as in the development of these presentations and trainings.

Protection and Advocacy

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 mental illness and their families, and to investigate reports of abuse and neglect in facilities or community programs that provide care or treatment for individuals with mental illness. These facilities and programs, which may be public or private, include hospitals, nursing homes, community-based programs, educational settings, homeless shelters, jails, and prisons. The DRW provides individual advocacy services and conducts investigations throughout the state. DRW provides systems advocacy on a wide range of rights and services issues and conducts training when requested for consumers, family members, mental health providers, attorneys, and the general public on issues relating to the rights of persons with mental illness, stigma, recovery, recovery-oriented services, trauma informed services, and access to appropriate services.

The above activities 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.

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.

Employment Services for Adults

Adults with 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 mental illness may have difficulty maintaining employment due to job stress and variations in the status of their disorder.

Many individuals with significant mental illnesses develop employment plans with the Department of Workforce Development's Division of Vocational Rehabilitation (DVR). In FFY 2006, DVR served over 8,000 consumers (24 percent of the total caseload) with mental illness as a primary impairment. DVR is concerned that employment success with this population continues to lag behind other disability groups.

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 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 mental illness, seek and retain employment.

Disability Program Navigators – Disability Program Navigators is a new program offered in Wisconsin and funded through the federal Department of Labor and the Social Security Administration. The program assists persons with disabilities (including 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 fourteen Disability Navigators working throughout the state and they are of racially diverse backgrounds (Hmong, African American, and Native American).

The Navigators will partner 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 Supported Employment Projects – In 2004-05, DVR and DMHSAS negotiated a new Memorandum of Agreement to establish three local project sites to implement Supported Employment for persons with serious mental illness. While the previous project was restricted to CSP, this project implements Supported Employment with CSPs plus targeted case management and other mental health programs in a different configuration in each county. The project has just completed one year of project funding and converted to a fee-for-service business relationship this year. Projects have successfully enrolled 48 participants. Sites have 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 are providing the vocational specialist staff to team with treatment staff in the process. The model being employed is based on evidence-based practices as identified by SAMHSA.

The model described above addresses Goal 5, Recommendation 5.2 of the President's Freedom Commission on Mental Health:

Goal 5--Excellent mental health care is delivered and research is accelerated.

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

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 DHFS Office of Independence and Employment. 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 mental illness, Independent Living Centers, county human service agencies, developmental disability advocacy agencies and others. Examples of projects involving individuals with serious and persistent mental illness include the 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 and directly engaging individuals with mental illness in project planning and advisory capacities.

The Social Security Administration has granted WPTI a demonstration waiver 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 mental illness. In addition, 14 of the other contracted agencies actively work with individuals living with 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).

Housing

In Wisconsin, the vision of the system redesign 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 FFY 2008 Wisconsin Mental Health State Plan

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). 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 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 will apply for funds to support an additional Shelter Plus Care program, to address housing needs in the Waukesha area

In addition to Projects for Assistance in Transition from Homelessness (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 the state 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 Continuation 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, more counties volunteering to participate would provide a more accurate understanding of the number of individuals who are homeless in the state.

There are 31 counties that operate certified crisis programs under Wisconsin statutes HFS 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.

In June 2004, DMHSAS issued a memo to all counties in Wisconsin outlining a new priority to improve services to persons who are homeless and have a mental illness. A new priority was established for county use of MHBG funds for providing services to people who are homeless with a mental illness. The Counties were also requested to increase efforts to serve people who are homeless and have a mental illness through immediate action or priority placement on waiting lists. Counties were also directed to develop performance targets and improve data reporting on the services they provide to homeless persons with a mental illness. In the 2007 MHBG budget, an additional \$26,000 was allocated to homeless projects, bringing the total earmarked for best practice treatment for homeless individuals to \$74,000.

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 mental illness, due to the side effects of many psychotropic medications.

The above activities address Goal 1, Recommendation 1.2; and Goal 4, Recommendation 4.4 of the President's Freedom Commission on Mental Health:

Goal 1--Americans understand that mental health is essential to overall health.

Recommendation 1.2--Address mental health with the same urgency as physical health.

Goal 4--Early mental health screening, assessment, and referral to services are common practice.

Recommendation 4.4--Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Educational Opportunities

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. In FFY 2004, DVR provided financial assistance for 8,959 consumers with mental illness to attend college or vocational/technical schools.

The educational opportunities described above address Goal 4, Recommendation 4.2 of the President's Freedom Commission on Mental Health:

Goal 4--Early mental health screening, assessment, and referral to services are common practice.

Recommendation 4.2--Improve and expand school mental health programs.

Services Provided for Individuals with Co-Occurring Substance Use and Mental Health Issues

DHFS 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. DHFS has partnered since 2000 with the Great Lakes 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 and Family Services continues to seek out additional federal and other resources to provide additional services.

In the Substance Abuse Treatment Administrative Rule (HFS 75), substance abuse providers are required to refer persons who have mental health issues into treatment. Mental health outpatient administration rules do not have a similar requirement to refer persons into substance abuse treatment. However, work is underway to revise the mental health outpatient rule and will include this requirement. Mental health and substance abuse service providers operate with limited budgets and some reluctance to jointly fund 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 will be held in fall 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.

Statewide Urban/Rural Women’s AODA Treatment Project--The statewide Urban/Rural Women’s AODA Treatment Project targets funding of \$2,206,900 from the Substance Abuse Block Grant with eight family-centered treatment programs to expand services in key underserved areas throughout the state. Services include women-specific treatment in the rural northwest, rural north central, west, south central, east, and rural east regions. The program design includes using the relational/cultural model and integrated services in the treatment approach.

Milwaukee AODA/TANF Services System (NEXUS)--Milwaukee AODA/TANF Services System NEXUS provides \$5,000,000 annually for alcohol and other drug abuse treatment programs for Temporary Assistance for Needy Families (TANF) eligible individuals in Milwaukee County. NEXUS is built on a strong foundation of collaborative learning and community partnership needed for consumers to recover from AODA issues in a positive, supportive, and nurturing environment. All families receive a single coordinated care plan that builds on family strengths, is needs driven, and based on the unique values, norms, and preferences of the family, and community.

Nearly 80 percent of clients in the Urban/Rural Women’s AODA Treatment Project reported experiencing psychological or emotional problems at admission. By treatment discharge (six or more months after admission), 20 percent of those completing services reported such problems. In the NEXUS system nearly 55 percent of the females and 50 percent of the TANF-eligible males report experiencing psychological distress at admission. By discharge, which is approximately 4 months after treatment, the distress has been reduced to 22 percent for females and 11 percent for males.

All of the initiatives listed above meet Goal 4, Recommendations 4.3 and 4.4 of the President's Freedom Commission on Mental Health:
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.

Challenges – Wisconsin continues to be challenged by the pervasive culture of alcohol use in this state. In order to make a difference in the number of people who binge drink or drive while intoxicated, emphasis is needed to work on the community values that support this behavior and use evidence-based treatment and prevention efforts targeted at this issue.

Data on Adult Substance Abuse

Wisconsin recently received a Strategic Prevention Framework State Incentive 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 2006 “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, Tobacco 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. 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 1½ times the national rate of arrests for operating while intoxicated and more than three times the national rate of arrests for liquor law violations. One surprising finding is that Wisconsin has a lower rate of alcohol-related liver cirrhosis than the national average.

Lung cancer and chronic obstructive pulmonary disease are two catastrophic consequences of tobacco consumption. So far, the mortality rates for these two diseases in Wisconsin have been lower than the national average. However, in the past ten years, there has been no reduction in the mortality rates for these two diseases. Additionally, crime associated with illicit drug use also negatively affects the community. From 1996 to 2004, the rate of arrests for drug law violations was higher in Wisconsin compared to the national average.

Alcohol Consumption

In 2005, Wisconsin had the highest prevalence of alcohol use in the country. The percent of high school students who initiated alcohol use before the age of 13 was similar to the national average and has been decreasing over the past five years. However, current use of alcohol among both youth and adults was among the highest in the country. In 2005, Wisconsin high school students reported the highest rate of current alcohol use among all reporting states and the fifth highest rate of binge drinking. Among adults, Wisconsin had the highest prevalence of binge drinking, current alcohol use, and chronic heavy drinking in the country. The rate of per capita alcohol consumption was also among the highest in the nation.

Tobacco Consumption

Tobacco consumption is decreasing in Wisconsin. Among high school students, the prevalence of smoking has dropped considerably, from 36% in 1997 to 23% in 2005. The prevalence of current smoking among adults dropped slightly between 2000 (23%) and 2005 (21%). One trend worth noting is the reduction in per capita tobacco consumption. Wisconsin's per capita consumption dropped almost 20% between 1996 and 2005, representing a reduction of 19 packs per person annually in the past 10 years. However, smoking prevalence remains high in certain demographic groups. American Indian and African American adults still smoke at rates far higher than the Wisconsin average (32% and 30%, respectively, in 2005).

Other Drug Consumption

The use of drugs other than alcohol and tobacco 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.

A number of challenges exist in Wisconsin for both the MH/AODA service delivery systems. For example, service systems have strict eligibility criteria, which can make access to services difficult. Providers often overlook assessing and diagnosing both substance abuse disorders in persons with mental illness and mental illness in persons with substance abuse disorders. There is a need to promote comprehensive screening and assessment tools, which could lead to effective identification and service delivery. A limited number of qualified, culturally competent and cross-trained staff and/or collaboration among appropriate and qualified providers who understand both areas exist. Staff from one discipline may resist partnership with the other discipline. Also, special services are limited. Of 1,315 outpatient treatment providers, only 294 are certified as both mental health and substance abuse treatment providers. Ten of 159 day-treatment providers and eleven of 101 inpatient treatment providers certified by DHFS are certified as treatment providers for consumers with co-occurring disorders. Only 67 of 685 substance abuse treatment programs listed in the Wisconsin Substance Abuse Services Directory are identified as serving consumers with co-occurring disorders,

Human Services Disaster Preparedness Planning

The DMHSAS has a contract from the Division of Public Health to increase human services/mental health planning and recovery capacity in the event of a natural disaster or bioterrorism event. These funds are part of the Centers for Disease Control Public Health Emergency Preparedness Grant to DHFS. During FFY 2008 Wisconsin Mental Health State Plan

2004, project staff completed a statewide plan for human services/mental health disaster preparedness and response. The plan was distributed to 72 counties and 11 tribes to assist them to prepare local plans. In addition, the project conducted a survey of the counties and tribes to assess preparedness levels and the need for consultation and training. During 2006-2007, the project is providing onsite technical assistance and training to counties in Wisconsin to improve their planning and response/recovery capacity. This effort incorporates a focus upon special populations that might require additional assistance in the event of a disaster including persons with serious and persistent mental illness, persons with substance abuse/dependency treatment needs, and individuals with physical or sensory disabilities. The overall goal is to incorporate mental health/substance abuse/human services planning and response capacity in the emergency management effort at the local level.

The human disaster planning activities outlined above address Goal 1, Recommendation 1.2; and Goal 3, Recommendation 3.2 of the President's Freedom Commission on Mental Health:

Goal 1--Americans understand that mental health is essential to overall health.

Recommendation 1.2--Address mental health with the same urgency as physical health.

Goal 3--Disparities in mental health services are eliminated.

Recommendation 3.2--Improve access to quality care in rural and geographically remote areas.

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 DHFS discussions as a key spokesperson: providing information and feedback regarding transformation of the systems: monitoring two consumer agency contracts: and partnering externally with individual consumers and groups to conduct trainings.

In addition, the Consumer Relations Coordinator is a key member and staff support to the Statewide Recovery Implementation Task Force, which is an advocate and consumer driven group of approximately 20 leaders from across the State. The Task Force meets every other month. Through a committee structure, the Recovery 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.

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. The contract outcomes include development and support of up to 10 consumer run, peer support grantee sites in various areas of Wisconsin. Five funded sites received funding from the GEP contract 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 are 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 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. The DMHSAS supports these efforts through an annual grant to the WI Clubhouse Coalition for an educational retreat.

The National Alliance on Mental Illness (NAMI) Wisconsin, Inc. has offered consumer and family education for over twenty-five years which includes working with NAMI National. NAMI Wisconsin is a grassroots organization with over 40 affiliates statewide and its membership represents 5,000 mental health consumers, family members, mental health and other professionals. Consumers, who self-identify as mental health consumers, represent nearly 40 percent of the total NAMI Wisconsin membership. NAMI Wisconsin promotes recovery principles and provides recovery-based trainings and other programs to meet regional and county mental health training needs statewide.

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.

The activities described above address Goal 2, Recommendations 2.2 and 2.5 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.

Recommendation 2.5--Protect and enhance the rights of people with mental illnesses.

Services for Special Populations

Wisconsin Forensic Programs

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 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. During fiscal year 2006, the Conditional Release program served an average of 268 persons per day, who primarily have diagnoses of schizophrenia or other psychotic and mood disorders. The average annual cost per client was \$14,765, compared to a range of \$244,550 to \$223,745 for care and treatment at one of the two state institutions. The program not only produces direct cost savings, but significant indirect cost savings and positive outcomes for the clients and society:

- Only 2.4 percent committed a new crime (1.0% a non-violent offense and 1.4% a violent offense);
- Only 13.2 percent were revoked (versus 38 percent for similar individuals exiting corrections without this program);
- 36 percent achieved competitive employment; and
- 72 percent were living independently.

The Wisconsin Resource Center serves persons in the Wisconsin prison system with a severe and persistent mental illness. These persons have been convicted, pled guilty, or pled no contest to a crime and are serving a prison term. Those persons whose mental health needs cannot be met in the prison setting are transferred for specialized mental health services to the Wisconsin Resource Center.

The 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.

In addition, the Mental Health Criminal Justice Committee of the WI Council on Mental Health will continue to work with the Department of Corrections on implementing a benefits application process for inmates with mental health disorders who are being discharged from the prison system. The committee also is working on initiatives to improve inmate access to mental health and substance abuse services upon release or discharge. This work includes collaboration with DHFS on enhancing a wide range of services to inmates.

Mental Health/Substance Abuse Needs of Older Adults

Wisconsin population estimates for 2005 indicate there are 973,313 older adults aged 60 years or older. There are 727,587 older adults over the age 65, and 116,221 older persons are aged 85 or older. The proportion of people aged 65 years and older in Wisconsin was higher than that of the total national average (13.1 percent versus 12.4 percent) in year 2000 at the time of the Census. And, data estimated for 2005 (from the Bureau on Aging and Disability Resources) tell us the percent of persons age 60 years old and older has increased to make up nearly 17.5% of the state population.

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 7 to 15 million individuals. Using these 2005 national population estimates in Wisconsin and the 2005 MH/SA prevalence estimate, (1 in 4 older adults have a significant mental disorder). The Department of Health and Family Services expects to see approximately 243, 328 older adults (60+ Yrs) or 181,896 elders 65+ years, 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+ (out of 97,265 total persons in this target group, or 9%) were receiving a public mental health service, and approximately 2,225 adults over age 60 (out of 81,181 persons or 2.7%) were receiving a substance abuse service. This does not reflect those individuals who receive services from Medicare.

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 FFY 2008 Wisconsin Mental Health State Plan

development of the Wisconsin Geropsychiatry Initiative (WGPI). The WGPI began when a geropsychiatrist, Dr. Tim Howell, initiated a collaborative with a group of persons interested in making geropsychiatric expertise available to community workers serving older persons with mental health/substance abuse needs. The group started meeting in 2004-2005 to refine and adopt an effective teaching model/method called the Star Method. In FFY 2005, the WGPI began providing indirect care to older persons via case-specific consultation by geropsychiatrists to long-term care, geriatric, and public agencies, primarily focused in the Milwaukee area. This WGPI initiative received an "Award for Educational Innovation," from the Annapolis Coalition on Behavioral Health Workforce Education in 2004.

In addition to the WGPI initiative, state staff continues to work with county agencies implementing a CCS program to ensure that this lifespan program serves older adults. The CCS benefit could be a significant source of Medicaid funding for older adults to use to access mental health and substance abuse services. One of the core requirements of a county CCS plan is outreach to all populations. This is of particular relevance to older adults with mental illness who self isolate. They are not responsive to the usual forms of outreach through newspapers, advertising in key locales in the community and booths at health fairs. DMHSAS has set aside money for outreach and treatment pilots in the 2008 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 mental illness because of stigma and self isolation.

The FFY 2007-2008 plan for development of mental health/substance abuse services for elders includes:

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

Deaf and Hard of Hearing Persons with Mental Illness

Since January 2003, a Mental Health Specialist for Deaf and Hard of Hearing Services has been working in DMHSAS to develop a statewide plan to address the needs and concerns regarding access to mental health services for deaf, deaf-blind, and hard of hearing persons. The plan will focus on how to provide culturally competent, culturally affirmative treatment services utilizing assistive devices and other communications technology. Specific activities include:

- Developing, funding and implementing a Deaf Crisis Intervention Team;

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

Veterans' Mental Health Services

The DMHSAS continues its efforts to collaborate with the Veteran's Administration on increasing access to mental health services for veterans. The availability of mental health services for veterans is becoming a higher profile issue with the increasing number of soldiers returning home from Iraq and Afghanistan. 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 telemedicine. The Veteran's Administration is using video equipment for telemedicine (or telehealth) 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 telemedicine. The DMHSAS and Regional Area Administration Offices of DHFS will assist in informing counties of the availability of these services and informing providers of the special needs of returning veterans.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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 0.5 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 2008 who are readmitted within 30 days.
Measures:	<i>Numerator:</i> The number of adults discharged from all state and county psychiatric hospitals in FFY 2008 who are readmitted within 30 days. <i>Denominator:</i> The number of adults discharged from all state and county psychiatric hospitals in FFY 2008.
Sources of Information:	Human Services Reporting System (HSRS) data.
Special Issues	This is a national outcome measure required by CMHS. The data to monitor readmissions to psychiatric hospitals for adults will be taken directly from Uniform Reporting System (URS) Data Table 21, which states are required to report in the annual MHBG Implementation Report.
Significance:	Community-based treatment is at the core of the Wisconsin service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of other community-based treatment approaches.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:					
Decrease psychiatric hospital readmissions within 30 days ¹	FFY 2004 Actual	FFY 2005 Actual	FFY 2006 Actual	FFY 2007 Projected	FFY 2008 Target
Value:	10.6%	11.4%	10.0%	9.4%	8.9%
Numerator:	1,067	1,217	896	845	796
Denominator:	10,088	10,629	8,918	8,946	8,946

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

Wisconsin projects an annual decrease of approximately 0.5 percent in the readmission rate over the FFY 2008 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 will expand the availability of outpatient MA-funded mental health services. In FFY 2007, there are currently 20 counties with full or provisionally certified CCS programs and Wisconsin projects 26 counties will have certified programs in FFY 2008.
- Increasing the number of crisis programs through the five multi-county initiatives will also serve to reduce the number of inpatient placements, including re-admissions. Increased crisis services will serve to prevent unnecessary admissions to psychiatric hospitals, but will also serve to prevent unnecessary readmissions. 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.
- When individuals are discharged from psychiatric hospitals, these are the expected increased service options that will be available to them. Becoming engaged with these service/program options after discharge from a psychiatric hospital should reduce the incidence of readmissions.

The initiatives described above address Goal 5, Recommendation 5.3 of the President's Freedom Commission on Mental Health:

Goal 5--Excellent mental health care is delivered and research is accelerated.

Recommendation 5.3--Improve and expand the workforce providing evidence-based mental health services and supports.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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 approximately 0.5 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 2008 who are readmitted within 180 days.
Measure:	<i>Numerator:</i> The number of adults discharged from all state and county psychiatric hospitals in FFY 2008 who are readmitted within 180 days. <i>Denominator:</i> The number of adults discharged from all state and county psychiatric hospitals in FFY 2008.
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.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator: Decrease psychiatric hospital episodes within 180 days ¹	FFY 2004 Actual	FFY 2005 Actual	FFY 2006 Actual	FFY 2007 Projected	FFY 2008 Target
Value:	19.9%	22.0%	20.0%	19.5%	19.0%
Numerator:	2,009	2,343	1,781	1,853	1,805
Denominator:	10,088	10,629	8,918	9,500	9,500

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

Wisconsin projects an annual decrease of approximately 0.5 percent in the readmission rate over the FFY 2008 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 will expand the availability of outpatient MA-funded mental health services. In FFY 2007, there are currently 20 counties with full or provisionally certified CCS programs and Wisconsin projects 26 counties will have certified programs in FFY 2008.
- Increasing the number of crisis programs through the five multi-county initiatives will also serve to reduce the number of inpatient placements, including re-admissions. Increased crisis services will serve to prevent unnecessary admissions to psychiatric hospitals, but will also serve to prevent unnecessary readmissions. 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.

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

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 3:	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 in FFY 2008.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Evidence-Based Practices Used.
Indicator:	Number of evidence-based practices used for adults in the state in FFY 2008.
Measure:	Number of evidence-based practices used for adults in the state in FFY 2008.
Sources of Information:	DMHSAS records.
Special Issues and Strategy:	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 2007. 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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Number of Evidence-based Practices Used	Actual	Actual	Actual	Projected	Target
Value:	1	2	3	4	5
Numerator:	_____				
Denominator:	_____				

Action Plan

In FFY 2007, there are 80 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. In addition, the Division of Vocational Rehabilitation (DVR) began its supported employment project, which uses the Supported Employment Fidelity Scale published by SAMHSA, in CY 2005. 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.

The EBP grants will also be awarded in 2008 to help additional counties continue their implementation and quality improvement work.

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

The activities described above address Goal 2, Recommendation 2.3 and Goal 5, Recommendation 5.2 of the President's Freedom Commission on Mental Health:
Goal 2--Mental health care is consumer and family driven.
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 5.2--Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 3:	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 in FFY 2008.
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 2008.
Measure:	Number of adults receiving evidence-based practices in the state in FFY 2008.
Sources of Information:	CSP Monitoring report. Other sources to be determined.
Special Issues and Strategy:	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 2007. 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 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 mental illnesses.

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

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:

Number of Adults

Receiving Evidence-based Practices ¹	FFY 2004 Actual ²	FFY 2005 Actual	FFY 2006 Actual	FFY 2007 Projected	FFY 2008 Target
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Value:	5,032	5,619	5,624	5,831	6,000
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Numerator:

Denominator:

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc. Note that huge growth is not expected in CSP participation as CCS is also enrolling consumers at this time

Note 2: Includes data from 80 CSP programs, and 3 CCS programs in full implementation of EPB's.

Action Plan

In FFY 2007, there are 80 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. In addition, the Division of Vocational Rehabilitation (DVR) began its supported employment project, which uses the Supported Employment Fidelity Scale published by SAMHSA, in CY 2005. DVR anticipates serving 15 clients at each of its three demonstration sites each year for a total of 45 clients served. 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.

The EBP grants will also be awarded in 2008 to help counties continue their implementation and quality improvement work.

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

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 4:	Improve client perception of care. (National Outcome Measure)
Objective:	Improve client perception of care. (National Outcome Measure)
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 2008.
Measure:	<i>Numerator:</i> the number of adults with a "positive" response about the outcome of their treatment measured by the Outcomes scale in FFY 2008. <i>Denominator:</i> the total number of adults responding to the survey in FFY 2008.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Client perception of care	Actual	Actual	Actual	Projected	Target
Value:	64.3%	63.2%	61.0%	63.0%	65.0%
Numerator:	340	319	255	315	325
Denominator:	529	505	418	500	500

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 2007 has been budgeted to fund the administration of the satisfaction surveys and, pending federal approval; DIG funds have been budgeted for administering the survey in FFY 2008 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. In FFY 2008, Wisconsin will begin implementing strategies to increase satisfaction with these low-scoring services or programs.

It is the intent of the DMHSAS to move towards an outcome-based, consumer-focused system where quality improvement is built into the programs at the local level. To that end, Wisconsin will develop mechanisms to collect outcome data and quality indicators and intends to change the way in which we evaluate the success of services and supports provided. A functional screen that local agencies can use to develop indicators from has been developed, so that quality improvement efforts can be data driven. Wisconsin has also developed a consumer outcomes measurement tool named the Recovery-Oriented System Assessment (ROSA) which we can use in a variety of ways: as a teaching tool; a measurement tool; an assessment adjunct; and a peer review mechanism. This QI effort has begun in five counties in FFY 2007 and will be offered to an expanding number of counties in the coming year to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance. In 2007, money from the mental health block grant increase will be 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 to collect data at the local level that they can use as indicators of annual progress in recovery.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 5:	Implement new CCS programs to increase funding for an expanded array of services.
Objective:	To implement the CCS benefit in 10 percent of Wisconsin's counties annually from FFY 2008.
Population:	Adults and elders 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 2008.
Measure:	<i>Numerator:</i> the number of counties who implement the new CCS benefit in FFY 2008. <i>Denominator:</i> the total number of Wisconsin counties in FFY 2008.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator: Expand array of services with CCS	FFY 2004 Actual	FFY 2005 Actual	FFY 2006 Actual	FFY 2007 Actual	FFY 2008 Target
Value:	0%	13.9%	26.4%	29.2%	36.1%
Numerator:	0	10	19	22	26
Denominator:	72	72	72	72	72

Action Plan

Given the number of counties who have applied or expressed interest in obtaining certification to provide the CCS service benefit in FFY 2007, an additional 3 counties are expected to be certified in FFY 2007 to bring the total to 22. In FFY 2008, Wisconsin plans to certify at least 4 additional CCS programs. This will increase the total number of certified counties to 26. 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. In FFY 2008, Wisconsin hired an individual contractor to aid in the training and technical assistance as well as in the certification approval process. The individual contractor will continue to perform these functions at least through FFY 2007. The DMHSAS has hired a full-time CCS Statewide Coordinator in a State staff position. This position ensures a permanent focus on the ongoing development of CCS programs statewide.

It is anticipated that annually approximately 4-5 counties will become certified. To further facilitate start-up and proper implementation, the DMHSAS will annually award up to \$186,900 in State GPR funds to developing CCS 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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 5:	Increase or retain employment for mental health consumers. (National Outcome Measure)
Objective:	To increase the percentage of consumers with new or continued employment by 1 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 2008.
Measure:	<i>Numerator:</i> Number of adults 18 and older with SMI who are employed in FFY 2008. <i>Denominator:</i> Number of adults 18 and older with SMI who are employed, unemployed, or not in the labor force in FFY 2008.
Sources of Information:	HSRS data.
Special Issues and Strategies	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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Increase or retain employment ¹	Actual	Actual	Actual	Projected	Target
Value:	24.4%	25.0%	28.1%	29.1%	30.1%
Numerator:	3,849	4,255	3,949	4,094	4,235
Denominator:	15,756	17,024	14,069	14,069	14,069

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods. For example, FFY 2006 data is from CY 2005.

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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 6:	Decrease criminal justice involvement for mental health consumers. (National Outcome Measure)
Objective:	To decrease the percentage of adult mental health consumers involved with the criminal justice system by 4 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 2008 after being arrested in FFY 2007.
Measure:	<i>Numerator:</i> Number of adults 18 years and older with SMI who had no arrests in FFY 2008 after being arrested in FFY 2007. <i>Denominator:</i> Number of adults 18 years and older with SMI who were arrested in FFY 2007.
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 2007 or FFY 2008. The indicator focuses on adults arrested in FFY 2007 to see if they were able to avoid being arrested again in FFY 2008.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Decreased criminal justice involvement	Actual	Actual	Actual	Actual	Target
Value:	Not applicable	not applicable	75.0%	71.0%	67.0%
Numerator:			30	28	27
Denominator:			40	40	40

Action Plan

The action plan for 2008 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. At the DMHSAS conference in the Fall of 2007, there is a workshop on mental health court development. 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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 7:	Increase stability in housing. (National Outcome Measure)
Objective:	To decrease the percentage of consumers who are homeless by 0.2 percent annually.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Decrease homelessness.
Indicator:	The percentage of adults with SMI who are homeless in FFY 2008.
Measure:	<i>Numerator:</i> Number of adults 18 and older with SMI who are homeless in FFY 2008. <i>Denominator:</i> Number of adults 18 and older with SMI receiving services through the public mental health system in FFY 2008 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. The number of individuals who are homeless is reported in the HSRS for only consumers with SMI, so the indicator does not describe the percentage of total mental health consumers who are homeless.
Significance:	Having a stable living situation is an essential condition to being able to adequately cope with a mental health disorder.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Increase stability in housing ¹	Actual	Actual	Actual	Projected	Target
Value:	not applicable	not applicable	2.3%	2.1%	1.9%
Numerator:			402	371	336
Denominator:			17,682	17,682	17,682

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods. For example, FFY 2006 data is from CY 2005.

Action Plan

For 2008, DMHSAS has increased the amount of dollars allocated to innovative programs for the homeless. \$74,000 has been allocated to these programs for the SMI population with unstable housing. In addition, the DMHSAS will collaborate with the Department of Commerce, responsible for the PATH program and HUD housing to target SOAR training in the southeastern region of the state where the locus of the homeless population with mental illness is, primarily because of prison releases to that area. The state has applied for a technical assistance grant to plan how to implement SOAR training across systems to facilitate income and housing stability. By targeting the area of the state where the population census for homeless is greatest, we hope to improve the overall housing stability for the population reported on HSRS.

FFY 2008

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 2 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 2008.
Measure:	<i>Numerator:</i> Number of adults 18 and older with SMI who agree they have social supports to rely on in their community in FFY 2008. <i>Denominator:</i> 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 2008.
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 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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Increase social supports	Actual	Actual	Actual	Projected	Target
Value:	not applicable	not applicable	63.3%	66.3%	69.3%
Numerator:			290	304	317
Denominator:			458	458	458

Action Plan

In 2008 the DMHSAS is starting 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.

DMHSAS has written 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. Recently, 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 has scheduled the first training for October of 2007 with five initial county agencies and their staff. 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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 10:	Improved level of functioning. (National Outcome Measure)
Objective:	To increase the percentage of consumers with improved functioning by 3 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 2008.
Measure:	<i>Numerator:</i> 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 2008. <i>Denominator:</i> Number of adults 18 and older with SMI responding about their general ability to function on the MHSIP satisfaction survey in FFY 2008.
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 5-point scale with five survey questions to generate an overall scale score for how their ability to function has changed as a direct result of the mental health services they've received in the last year. The survey questions address areas of general functioning such as "My symptoms are not bothering me as much" and "I am better able to take care of my needs".
Significance:	One of the primary goals of mental health services is to improve the consumer's ability to cope with their mental health disorder and function within his/her different domains of life.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Improved level of functioning	Actual	Actual	Actual	Projected	Target
Value:	not applicable	not applicable	61.7%	64.7%	67.7%
Numerator:			276	289	303
Denominator:			447	447	447

Action Plan

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

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

STATE PLAN PERFORMANCE INDICATOR

FFY 2008

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 in FFY 2008.
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 2008.
Measure:	Number of adults receiving IDDT as an evidence-based practice in the state in FFY 2008.
Sources of Information:	Individual reports from pilot counties funded to implement EBP's.
Special Issues and Strategy:	Wisconsin is currently facilitating the implementation of EBP's through the provision of grants to 5 counties. Two counties are implementing IDDT and are reporting on the number of consumers served. 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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:					
Number of Adults Receiving Integrated Dual Disorder Treatment ¹					
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
	Actual	Actual	Actual	Actual	Target
Value:	0	0	0	229	250
Numerator:					
Denominator:					

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

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. The EBP grants will also be awarded in 2008 to help counties continue their implementation and quality improvement work.

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

FFY 2008

Criterion 1

Goal 12:	To facilitate the use of Supported Housing as an evidence-based practice for adults.
Objective:	To facilitate the use of Supported Housing as an evidence-based practice for adults by funding their implementation and disseminating training resources in FFY 2008.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Adults Receiving Supported Housing.
Indicator:	Number of adults receiving Supported Housing as an evidence-based practice in the state in FFY 2008.
Measure:	Number of adults receiving Supported Housing as an evidence-based practice in the state in FFY 2008.
Sources of Information:	No current source of Supported Housing data exists.
Special Issues and Strategy:	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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:

Number of Adults

Receiving Supported
Housing¹

FFY 2004
Actual

FFY 2005
Actual

FFY 2006
Actual

FFY 2007
Actual

FFY 2008
Target

Value:

0

0

0

0

0

Numerator:

Denominator:

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

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). None of the current 5 counties chose to implement Supported Housing at this time. The EBP grants from the MHBG are offered to counties for three years. At the end of this period, the funds will be offered to new counties whom will also be given the option to choose which EBP will best meet the needs of their consumers, including Supported Housing. The first three-year grants will end after FFY 2008 at which time Wisconsin will be able to reassess if the new counties will be implementing Supported Housing.

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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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% 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 2008.
Measure:	<i>Numerator:</i> The number of adults receiving Supported Employment services in FFY 2008. <i>Denominator:</i> The number of adults receiving Supported Employment services in FFY 2007.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:					
Number of Adults Receiving Supported Employment ¹					
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
	Actual	Actual	Actual	Actual	Target
Value:	0	0	100%	82%	104%
Numerator:			45	37	47
Denominator:			45	45	45

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

The Division of Vocational Rehabilitation (DVR) began a Supported Employment project in CY 2005. DVR anticipates serving 15 clients at each of its three demonstration sites each year for a total of 45 clients served. In 2004-05, DVR and DMHSAS negotiated a new Memorandum of Agreement to establish three local project sites to implement Supported Employment for persons with serious mental illness. While the previous project was restricted to CSP, this project implements Supported Employment with CSPs plus targeted case management and other mental health programs in a different configuration in each county. Local community rehabilitation programs are providing the vocational specialist staff to team with treatment staff in the process. The model being employed is based on evidence-based practices as identified by SAMHSA. The contracts to provide Supported Employment services end after CY 2007. Discussions are currently underway to decide if the contracts will be renewed or not.

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 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 whether some local providers are already using Supported Employment and thus the reporting for this EBP could change in the future.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 14:	To facilitate the use of Family Psychoeducation as an evidence-based practice for adults.
Objective:	To facilitate the use of Family Psychoeducation as an evidence-based practice for adults by funding their implementation and disseminating training resources in FFY 2008.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Adults Receiving Family Psychoeducation.
Indicator:	Number of adults receiving Family Psychoeducation as an evidence-based practice in the state in FFY 2008.
Measure:	Number of adults receiving Family Psychoeducation as an evidence-based practice in the state in FFY 2008.
Sources of Information:	Individual reports from pilot counties who have been trained to implement Family Psychoeducation.
Special Issues and Strategy:	Training for Family Psychoeducation is being offered via contract for local providers in CY 2007 for the first time. It is difficult to predict the number of consumers to be served in CY 2007 based on the trainings provided, but more specific targets will be developed for this indicator in the FFY 2009 State Plan.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:

Number of Adults

Receiving Family

Psychoeducation¹

FFY 2004

FFY 2005

FFY 2006

FFY 2007

FFY 2008

Actual

Actual

Actual

Actual

Target

Value:

0

0

0

0

0

Numerator:

Denominator:

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

Wisconsin's SMHA has begun efforts to implement Family Psychoeducation for the first time in CY 2007 (reported as FFY 2008 in the above table). In its annual MHBG-funded contract with the state NAMI-Wisconsin, the BMHSAS has added Family Psychoeducation trainings to the NAMI-Wisconsin work plan. NAMI-Wisconsin has agreed to train their staff to become experts on Family Psychoeducation and then train local providers across the state to implement this EBP in their county. NAMI-Wisconsin is beginning in CY 2007 by training their staff and providing some trainings to local providers near the end of the year. The number of adult consumers actually served with Family Psychoeducation in CY 2007 is unknown as of the deadline for this Plan, but Wisconsin will be including targets in its future State MH Plans.

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 services similar to Family Psychoeducation, but the degree to which is being implemented with complete fidelity to the Family Psychoeducation model is unknown. Wisconsin has children's mental health wraparound programs in more than half of its counties, but has not clearly defined them as EBP's or best practices. The EBP work group's efforts will help determine whether some local providers are already using Family Psychoeducation and thus the reporting for this EBP could change in the future.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 15:	To facilitate the use of Illness Management and Recovery as an evidence-based practice for adults.
Objective:	To facilitate the use of Illness Management and Recovery as an evidence-based practice for adults by funding their implementation and disseminating training resources in FFY 2008.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Adults Receiving Illness Management and Recovery.
Indicator:	Number of adults receiving Illness Management and Recovery as an evidence-based practice in the state in FFY 2008.
Measure:	Number of adults receiving Illness Management and Recovery as an evidence-based practice in the state in FFY 2008.
Sources of Information:	Individual reports from pilot counties funded to implement EBP's.
Special Issues and Strategy:	Wisconsin is currently facilitating the implementation of EBP's through the provision of grants to 5 counties. Two counties are implementing Illness Management and Recovery and are reporting on the number of consumers served for the first time in CY 2007. It is difficult to predict the number of consumers to be served in CY 2007 based on the trainings provided, but more specific targets will be developed for this indicator in the FFY 2009 State Plan.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:					
Number of Adults Receiving Illness Management and Recovery ¹					
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
	Actual	Actual	Actual	Actual	Target
Value:	0	0	0	0	100
Numerator:	<hr/>				
Denominator:	<hr/>				

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

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 IMR. Counties have been using the SAMHSA EBP toolkit materials to guide their implementation. The EBP grants will also be awarded in 2008 to help counties continue their implementation and quality improvement work. Counties implementing IMR are asked to report the number of consumers served with this approach to the BMHSAS.

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

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 1

Goal 16:	To facilitate the use of Medication Management as an evidence-based practice for adults.
Objective:	To facilitate the use of Medication Management as an evidence-based practice for adults by funding their implementation and disseminating training resources in FFY 2008.
Population:	Adults with SMI.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Adults Receiving Medication Management.
Indicator:	Number of adults receiving Medication Management as an evidence-based practice in the state in FFY 2008.
Measure:	Number of adults receiving Medication Management as an evidence-based practice in the state in FFY 2008.
Sources of Information:	No current source of Medication Management data exists.
Special Issues and Strategy:	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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator:

Number of Adults

Receiving Medication
Management ¹

**FFY 2004
Actual**

**FFY 2005
Actual**

**FFY 2006
Actual**

**FFY 2007
Actual**

**FFY 2008
Target**

Value:

0

0

0

0

0

Numerator:

Denominator:

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

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 chose Illness Management and Recovery (IMR). None of the current 5 counties chose to implement Medication Management 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 Medication Management. The first three-year grants will end after FFY 2008 at which time Wisconsin will be able to reassess if the new counties will be implementing Medication Management.

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 some of them may be providing services similar to Medication Management, but the degree to which is being implemented with complete fidelity to the Medication Management 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 Medication Management and thus the reporting for this EBP could change in the future.

Criterion 2: Mental Health System Data Epidemiology

Wisconsin Demographics

Wisconsin is the 18th largest populated state in the United States. The population in 2004 was 5,532,955 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 fourteenth largest state in land area with 35.8 million acres and 1.1 million acres of water. The population of 5,441,196 has 4,103,132 or 75.4 percent are over the age of 18 and 706,418 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 Mental Illness for Adults

Wisconsin has used the following definition to identify its adult population with serious mental illness. Wisconsin State Statutes define chronic mental illness in section 51.01(3g) as:

"Chronic mental illness" means a 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 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.

Health and Family Services Chapter 63 of the Wisconsin Administrative Code defines Community Support Programs for chronically mentally ill persons. According to the admission criteria, chronic 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 Mental Illness for Admission to CSPs**

Diagnostic Category	DSM-IV Codes
Schizophrenic Disorders	295.30,.10,.20,.90,.60,.40,.70,295.40
Other Psychotic Disorders	297.1, 298.8, 297.3, 293, 298.9
Mood Disorders, including Bi-Polar I and II Mood Disorders	296.2,3,4,5,6,7,8, 300.4

Prevalence of Serious 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 “*Estimation of 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 nonaffective 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 updated 2004 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 4,119,320. When the county-estimated prevalence figures are summed, an estimated 233,154 Wisconsin adults have a serious mental illness which is 5.66 percent of the adult population.

**Table 12:
Wisconsin Adult Prevalence Estimates of SMI by County**

COUNTY	2004 Population Estimate (Age 18+)	Estimated % of Non-Institutionalized Adults with SMI	Estimated # of Adults with SMI	COUNTY	2004 Population Estimate (Age 18+)	Estimated % of Non-Institutionalized Adults with SMI	Estimated # of Adults with SMI
Adams	16,396	4.30%	705	Marathon	95,124	5.20%	4,946
Ashland	12,649	4.70%	595	Marinette	33,805	4.85%	1,640
Barron	34,756	4.70%	1634	Marquette	11,728	4.00%	469
Bayfield	11,737	4.40%	516	Menominee	2,819	5.40%	152
Brown	175,641	5.60%	9836	Milwaukee	691,828	6.70%	46,352
Buffalo	10,511	4.70%	494	Monroe	30,643	4.90%	1,502
Burnett	12,774	4.10%	524	Oconto	27,951	4.60%	1,286
Calumet	31,613	6.70%	2118	Oneida	29,324	4.30%	1,261
Chippewa	43,757	4.90%	2144	Outagamie	122,068	6.60%	8,056
Clark	24,057	4.60%	1107	Ozaukee	62,374	5.60%	3,493
Columbia	40,834	4.80%	1960	Pepin	5,569	4.40%	245
Crawford	12,920	4.60%	594	Pierce	29,154	5.80%	1,691
Dane	348,588	6.90%	24053	Polk	32,331	4.70%	1,520
Dodge	66,437	5.10%	3388	Portage	52,313	5.70%	2,982
Door	22,694	4.50%	1021	Price	12,148	4.20%	510
Douglas	33,404	6.20%	2071	Racine	140,159	5.40%	7,569
Dunn	31,937	5.70%	1820	Richland	13,542	4.60%	623
Eau Claire	73,680	5.70%	4200	Rock	114,287	5.30%	6,057
Florence	4,022	4.50%	181	Rusk	11,659	4.50%	525
Fond du Lac	74,502	5.10%	3800	Sauk	52,291	4.80%	2,510
Forest	7,623	4.20%	320	Sawyer	43,384	4.10%	1,779
Grant	38,545	5.10%	1966	Shawano	12,935	4.60%	595
Green	25,834	5.00%	1292	Sheboygan	31,161	5.10%	1,589
Green Lake	14,672	4.40%	646	St. Croix	85,928	5.50%	4,726
Iowa	17,233	4.90%	844	Taylor	14,480	4.90%	710
Iron	5,599	3.70%	207	Trempealeau	20,720	4.60%	953
Jackson	14,935	4.70%	702	Vernon	20,969	4.40%	923
Jefferson	58,531	5.30%	3102	Vilas	17,431	3.80%	662
Juneau	19,004	4.60%	874	Walworth	73,269	5.40%	3,957
Kenosha	113,799	5.50%	6259	Washburn	12,771	4.20%	536
Kewaunee	15,455	4.80%	742	Washington	90,616	5.40%	4,893
La Crosse	83,602	5.60%	4682	Waukesha	275,072	5.50%	15,129
Lafayette	11,871	4.70%	558	Waupaca	39,498	4.70%	1,856
Langlade	16,053	4.30%	690	Waushara	18,963	4.20%	796
Lincoln	22,588	4.70%	1062	Winnebago	123,281	6.60%	8,137
Manitowoc	62,807	4.90%	3078	Wood	56,665	5.00%	2,833
				State Total	4,119,320	5.66%	233,154

The estimates of percentage of non-institutionalized adults with SMI in this table is derived from "Estimation of the 12-month Prevalence of Serious Mental Illness (SMI)," Working Paper #8 (April, 1997, Kessler, Berglund, Walters, Leaf, Kouzia, Bruce, Friedman, et. al.

Treated Prevalence

Wisconsin counties are required to report annually using HSRS on the number of persons who receive mental health services in the past year. According to data from HSRS, in CY 2004 Wisconsin's public mental health system served 72,625 adults. Based on the estimated prevalence from Table 12 of 233,154 adults with SMI in Wisconsin, the public mental health system served 31.15 percent of the adults with SMI in Wisconsin.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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 1 percent the number of adults served through the public mental health system annually from FFY 2008.
- 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 2008.
- Measure:** *Numerator:* Number of adults 18 and older receiving services through the public mental health system in FFY 2008 minus the number of adults 18 and older receiving services through the public mental health system in FFY 2007.
Denominator: Number of adults 18 and older receiving services through the public mental health system in FFY 2007.
- 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, 2007.
- 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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Mental Health System Data Epidemiology

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Increase access to services ¹	Actual	Actual	Actual	Projected	Target
Value:	2.8%	7.7%	0.0%	-2.8%	1.0%
Numerator:	70,392 - 68,445	75,840- 70,392	75,799- 75,840	73,653- 75,799	74,390- 73,653
Denominator:	68,445	70,392	75,840	75,799	73,653

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

Action Plan

In FFY 2008, 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 continues to increase the number of certified CCS programs in the state on an annual basis by providing \$186,900 in program start-up funds. From FFY 2005 to FFY 2007, twelve counties became certified to provide the CCS benefit and another four are projected to be added in FFY 2008. Increasing the number of counties that provide CCS benefits will bring services to more adults in new areas of the state. Wisconsin uses the same funding for counties who wish to start a new Community Support Program (CSP). Wisconsin has added two more CSP's in the last two years for a total of 80 CSP's delivering mental health services in 64 of 72 counties. In FFY 2008, Wisconsin will target one of the remaining eight counties who do not have a CSP for program start-up funds.

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. Tele-health services are targeted to expand in FFY 2008 to two additional counties. Increased access to mental health services for the deaf and hard of hearing population is expected in FFY 2008. A Mental Health Interpreter Training is being provided in FFY2007 to sign language interpreters to provide them skills for interpreting between DHH mental health consumers and mental health professionals. The increased availability of MH interpreters is expected to increase access for the DHH population.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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 2007 to FFY 2008.
Measure:	<i>Numerator:</i> Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2008 minus the number of adults 18 and older receiving CCS services through the public mental health system in FFY 2007. <i>Denominator:</i> Number of adults 18 and older receiving CCS services through the public mental health system in FFY 2007.
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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Mental Health System Data Epidemiology

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Expand array of services with CCS ¹	Actual	Actual	Actual	Actual	Target
Value:	not applicable	not applicable	not applicable	227.1%	21.4%
Numerator:			229	749-229	909-749
Denominator:			not applicable	229	749

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods. For example, FFY 2006 data is from CY 2005.

Action Plan

Given the number of counties who have applied or expressed interest in obtaining certification to provide the CCS service benefit in FFY 2007, an additional 3 counties are projected to be certified to bring the total to 22. In FFY 2008, Wisconsin is targeting 4 additional CCS programs for certification. This will increase the total number of certified counties to 26. The number of consumers served in CCS programs has also 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 is an increase of 227 percent. Given the projected increase of 4 additional CCS certified programs in FFY 2008, the number of consumers served is expected to increase by 20 percent from 2007. The additional CCS programs targeted for certification in 2008 is based on those programs that are currently working, or have expressed interest, towards certification. Based on consumers served in 2007, the expected additional consumers served in each new CCS program in 2008 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 up to \$186,900 in State GPR funds to developing CCS 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 serves 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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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)
Goal:	Technology is used to Access Mental Health Care and Information
Objective:	To promote the use of a validated and tested web based screen that determines eligibility for programs for people with mental health and co-occurring issues beyond outpatient care.
Population:	Adults with Serious Mental Illness and co-occurring substance abuse issues
Criterion:	Comprehensive Community Based Mental Health Systems
Brief Name:	Expansion of the mental health and co-occurring functional screen
Related to Transformation	Yes
Indicator:	Number of counties using the functional screen
Measure:	Number of counties using the functional screen
Source of Information:	WI MEDS Electronic Screen warehouse
Performance Indicator	=Increase in percentage of counties using the screen to determine eligibility for mental health psychosocial rehabilitation services beyond outpatient care.

Fiscal Year : FFY 2008
Population: Adults with SMI
Criterion: Comprehensive Community Based Mental Health Service Systems

Performance Indicator: # of counties using the mental health / AODA functional screen	(2)	(3)	(4)	(5)	
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY 2007 Actual	FY 2008 Projected
Performance Indicator	0%	21%	31%	36%	50%
Numerator	0	15	22	26	36
Denominator	72	72	72	72	72

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 eligibility criteria across geographic boundaries. Screeners are required to be certified and there are web-based courses for each screen attached to the UW Madison Wisconsin teaching web site. Continuing education credits are earned for becoming a certified screener and the Division of Mental Health and Substance Abuse Services has a quality plan that assures the quality of screens being applied to the population looking for services and supports beyond mental health outpatient care.

The screen can give DMHSAS real time data on the population in Wisconsin being screened, it contains diagnoses, levels of functioning for all activities of daily living and assesses comprehensive levels of risk as well as identifying trauma. Local agencies can use it for a number of activities: data driven quality improvement efforts; assessing case load mix; assessing service gaps at the local level; and assessing progress in improvement of functional levels of consumers at both the individual and aggregate levels.

It is the intent of DMHSAS to promote the use of the screen state wide by 2010 for all certified psycho-social programs beyond outpatient services. This will ensure continuity of care for consumers within Wisconsin as they move from county to county, real time data for both the state and local agency and create the ability for the state to set functional outcomes for agencies who manage these programs. The screen is already mandatory for two major programs and the plan is to make it mandatory in the administrative code for CSP programs within the next two years.

The above activities address Goal 4, Recommendation 4.3 and Goal 6, Recommendation 6.1 of the President's Freedom Commission on Mental Health:
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.
Goal 6--Technology is used to access mental health care and information.
Recommendation 6.1--Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

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 in FFY 2008.
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 2008.
Measure:	Number of children receiving evidence-based practices in the state in FFY 2008.
Sources of Information:	EBP Survey.
Special Issues and Strategy:	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.

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Mental Health System Data Epidemiology

Performance Indicator:					
Increase MH/AODA identification ¹	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
	Actual	Actual	Actual	Actual	Target
Value:	not applicable	not applicable	not applicable	9.4%	10.0%
Numerator:			1,834	2,007-1,834	2,208-2,007
Denominator:			not applicable	1,834	2,007

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods. For example, FFY 2006 data is from CY 2005.

Action Plan

The promotion of the mental health and co-occurring functional screen that determines the need for CCS, CSP and COP for people with mental health issues serves a number of purposes for both the state and consumers. The primary advantage for consumers is that it creates a consistent determination statewide for the need for services, no matter which region they apply for services in. In addition, if they move from that region their screen and results can be electronically transferred to the area where they have relocated. In addition, the screen can be used both locally and statewide to determine functional indicators both individually and in the aggregate to create an annual “report card” of progress by the agency in meeting outcome indicators. DMHSAS has set aside block grant dollars to serve as an incentive for counties to begin using the screen voluntarily for CSP (it is already mandatory for COP and for CCS). 41 out of 72 counties are already using the screen, and this will promote an expansion to additional counties so that screen data can be used by the state and by local agencies to help in planning service arrays and analyzing their population demographics. DMHSAS will also work with agencies to teach them how to use the available data for quality improvement projects that are data driven.

Criterion 4: Targeted Services to Rural and Homeless 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 telehealth technology.

Rural Mental Health Services

Telehealth 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 telehealth 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 telehealth 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 telehealth, provided they have received the necessary training and meet program certification standards. The state Medicaid program will reimburse for MA-covered services delivered via telehealth 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.

Mental Health Services for the Elderly

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

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

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

5. Advocacy.

People 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.

Mental Health Block Grant and County Reporting. 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 2006. All the individuals listed received mental health services in 2006.

Received a Mental Health Service during 2006 and Residential Arrangement in Street or Shelter

	Total	Under 21	21-59	60+
Male	632	55	551	26
Female	498	25	437	36
Total	1130	80	988	62

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 and Family Services, 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 towards 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 3 year cycle.

The DMHSAS collaborates on the award amount annually with the Department of Commerce. For the last two 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.

Program Outcomes through 2006:

- Recidivism reduced from 70% to 35% for the population with mental health disorders
- People experience better psychiatric health overall with continuity of treatment
- People are re-connected with their families to a greater degree
- A total of 417 individuals were contacted, and a total of 311 were referred for follow up to the counselor at the Waukesha County mental health agency
- The following numbers accepted outreach services:
 - Short term (three contacts or less) 55
 - Medium term (up to three months) 54
 - Long term (three months or more) 82

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

The benefit specialist can be accessed immediately by people with mental health issues as soon as the ADRC receives state funding. The contract requires that they serve the mental health population by the third year of their contract, to ensure that they have the time to train staff and build up their required resource data base. There are currently 22 ADRC's, with a state plan to have ADRC's statewide by 2010. The DMHSAS has organized three web cast trainings for ADRC staff and is providing training and technical assistance upon request at a series of workshops and conferences. ADRC's have strong linkages with the local economic support units at each county, so access for application for medical assistance services as well as disability determination applications has been improved. Locations of the current ADRC's is available at: <http://dhfs.wisconsin.gov/LTCare/generalinfo/adrcmap.pdf>

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 Bureau of Managed Health Care Services 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 services delivery to the mental health individuals who are homeless with their partners at the county level and other willing providers.

Over the past thirty years, the care of people with serious mental illness (SMI) has shifted from state 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 never 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 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 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 people 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.

Governor’s Inter-Agency Council on Homelessness

In order to address the issue of chronic homelessness, Governor Jim Doyle announced the creation of an Inter-Agency Council on Homelessness in August 2004 to develop a 10-year plan to end chronic homelessness, emphasizing this population as a priority. The Governor's Inter-Agency Council on Homelessness plans to make recommendations in a report to the Governor in 2006 that will lead to:

- increasing the availability of and access to housing for homeless individuals and families,
- improving access to and expanding services for homeless individuals and families,
- improved coordination and planning between state departments,
- enhanced homelessness prevention efforts,
- continued improvement of data collection, and

- development of outcome based performance standards for the plan, identifying responsible agencies, and setting timelines for completion.

Projects for Assistance in Transition from Homelessness

One change that has resulted from the recommendations of the Inter-Agency Council has been the transfer of Projects for Assistance in Transition from Homelessness (PATH) funding from DHFS to the Department of Commerce as recommended in the Governor's Budget for 2005-2007. Federal PATH staff is assisting in the development of a Memorandum of Agreement (MOA) between DHFS and the Department of Commerce regarding the transfer. The MOA contains assurances that DHFS will continue to provide mental health and substance abuse services for individuals who are homeless. In the MOA, DHFS agreed that individuals who have a serious mental illness and are homeless will receive priority for county funding, and that as a condition for certification, all CCS programs will include a plan for providing outreach to this population. For FFY 2006, the federal PATH, administered by the Department of Commerce, will fund four 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; and the Emergency Shelter of the Fox Valley, serving Outagamie County, and expect to provide outreach to 1280 individuals and enroll at least 915 in services.

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. Three of the four PATH programs will have access to HUD funded Shelter Plus Care programs that provide permanent housing for people with serious mental illnesses who are homeless. The remaining program will use HUD Tenant Based Rental Assistance funds to provide permanent housing for PATH participants. With the help of the HUD funding, PATH participants will choose their housing first, and then receive other supportive services.

PATH funds are specifically targeted to help bring SMI homeless individuals to the services they need. Since many individuals who are homeless have both substance use disorders and serious mental illness, PATH programs plan to connect participants to integrated treatment – treatment for both disorders provided concurrently by the same clinician or team of clinicians in a single setting. The Milwaukee Healthcare for the Homeless program received a SAMHSA grant to help fund mental health and substance abuse services for individuals who are homeless, and Tellurian has a long history of providing treatment for co-occurring disorders. These two programs have agreed to share their expertise with the other PATH funded programs.

PATH funds will continue to be used for trauma training for people who work with persons who are homeless. 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 help create Crisis Intervention Teams (CIT) with police officers who are trained to understand mental health issues. Through a joint effort of the City of Appleton Police Department, NAMI and the county department of human services, training based on a CIT model developed by police officers in Memphis, Tennessee will continue to be offered twice a year. CIT officers will be taught to recognize some common forms of mental health problems and to understand the most effective means of communicating to de-escalate a person in crisis. This allows the consumers of mental health services to participate in decisions about their treatment and allows the police to offer appropriate services rather than jail or forced hospitalization. The key feature of this training is the fact that it is developed by police officers, for police officers, and delivered through the police academy. Any police officer or probation and parole officer in the state may apply to attend the training.

PATH funds will also be used 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 often proves to be too difficult. PATH is partnering with Brown County to bring a national expert to Wisconsin to provide training on the application process. Wisconsin is also fortunate enough to have two federal HOPE grants, at Milwaukee Health Care for the Homeless and the Department of Corrections in Oshkosh. DHFS and the Department of Corrections signed an agreement in July of 2004 to facilitate the social security application process for people with mental illness who are about to be released from prison. Staff from the Department of Commerce will work with PATH programs, HOPE funded projects, the Department of Corrections, and the Bureau of Disability Determination at DHFS to help develop a better process for determining eligibility for people who are homeless and have a serious mental illness. With the help of federal funds and training, an infrastructure that supports quicker determinations as well as some presumptive eligibility can be developed.

Other Efforts to Serve Persons who are Homeless with a SMI

The DMHSAS set aside \$48,000 MHBG dollars for CY 2006 for continuation funding for projects in Waukesha and Racine Counties that serve people with serious mental illnesses who are homeless and in jail. Following the model developed for discharge planning for people being released from prison, staff now work with individuals in these jails to connect them with mental health services prior to release from jail. In FFY 2007 and FFY 2008, the DMHSAS has set aside \$74,000 to promote expanded outreach and technical assistance on improving access to SSI benefits.

The DMHSAS issued a numbered memo regarding the MHBG for FFY 2006. The memo details an ongoing priority to improve efforts to serve persons with serious mental illness who are homeless. In addition to serving homeless mentally ill individuals, the counties will be instructed to prioritize coding homelessness data. In the past, there has been an under-utilization of the codes indicating homelessness. By making this a priority, the DMHSAS hopes there will be an increase in both the level of service and in the reporting of services for homeless individuals.

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 Continuum 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.

For FFY 2007, the federal Substance Abuse and Mental Health System Administration awarded \$705,000 in Projects for Assistance in the Transition to Homeless (PATH) to Wisconsin. The PATH funding is administered by the Wisconsin Department of Commerce. The funds were awarded through a Request For Proposal (RFP) process to five programs serving counties with the largest population of individuals who have a serious mental illness and are homeless. The National Coalition for the Homeless estimates that there are 7,316 homeless adults with serious mental illness in Wisconsin. The PATH funded projects expect to provide outreach to approximately 1,625 of those individuals in FF 2007.

There are 31 counties that operate certified crisis programs under Wisconsin statutes HFS 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.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 4

Goal 1: **To increase access to mental health services for adults with a SMI in rural areas.**

Objective: Increase by approximately two percentage points annually the number of rural counties with a CSP in FFY 2008.

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:	<i>Numerator:</i> The number of rural counties with certified CSPs in FFY 2008. <i>Denominator:</i> The number of rural counties in FFY 2008.
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 of they are rural. Another county will be selected in FFY 2008 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 DATA TABLE

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Targeted Services for Rural and Homeless Populations

Performance Indicator:					
Access to Services in Rural Areas	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
	Actual	Actual	Actual	Actual	Target
Value:	84.5%	84.5%	84.5%	87.9%	89.7%
Numerator:	49	49	49	51	52
Denominator:	58	58	58	58	58

Action Plan

The DMHSAS worked with Iron and Walworth Counties to help them get certified. Of the eight counties remaining without a CSP, seven of them are rural counties. Wisconsin plans to continue to try to increase the number of certified CSPs in the rural areas of the state on an annual basis by providing a portion of \$186,900 in program start-up funds to interested counties. The start-up funds are intended to help counties build the capacity to be a certified CSP provider. Certified CSPs are able to claim MA funding for consumer services which provides an important source of funding for program sustainability. Increasing the number of counties that have a CSP will bring services to more adults in new areas of the state.

In FFY 2008, Wisconsin plans to recruit and prepare another rural county to develop a certified CSP. Wisconsin will use its FFY 2006 assessment of counties that are ready and willing to pursue CSP certification to determine which county to work with in FFY 2008.

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 4

Goal 2:	Improve access to mental health services for adults who are homeless.
Objective:	Increase the number of adults with SMI who are homeless that receive mental health services by 5 percent annually from FFY 2008.
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 2008.
Measure:	<i>Numerator:</i> The number of adults with SMI who are homeless who receive mental health services in FFY 2008 minus the number of adults with SMI who are homeless who receive mental health services in FFY 2007. <i>Denominator:</i> The number of adults with SMI who are homeless who receive mental health services in FFY 2007.
Source(s) of Information:	The Human Services Reporting System (HSRS).
Special Issues and Strategy:	A memo is sent from the 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 2008 MHBG funds in CY 2008. Counties are required to report their budget plan and actual expenditures so this priority can be monitored.
Significance:	Individuals who are homeless are typically an underserved population with high levels of need.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Targeted Services for Rural and Homeless Populations

Performance Indicator:	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Access to services for adults who are homeless	Actual	Actual	Actual	Projected	Target
Value:	9.8%	45.0%	8.2%	10.9%	5%
Numerator:	1182-1076	1714-1182	1854-1714	2056-1854	2159-2056
Denominator:	1,076	1182	1714	1854	2056

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because it is the last full year of data available at the time the report is due. FFY 2008 data is from CY 2007, etc.

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 2007 informing counties to continue to prioritize individuals who are homeless for mental health services with the use of their FFY 2008 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.

Criterion 5: Management Systems

The Division of Mental Health and Substance Abuse Services (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 DMHSAS is comprised of the Administrator, John Easterday, a Deputy Administrator, Office Assistants, four institutions, the Office of Client Rights, the Conditional Release Unit and the Bureau of Mental Health and Substance Abuse Services (BMHSAS). The BMHSAS carries out the MHBG Plan. It consists of four Sections and 36.9 FTE's including the Director and the Director's Program Assistant.

In FFY 2007, the Mental Health Services and Contracts Section is responsible for monitoring the programmatic and administrative guidelines for the provision of mental health outpatient and inpatient 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 Wisconsin Council on Mental Health will also be provided by this section. Some integrated MH and Substance Abuse functions will also be 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, the elderly populations and Pre Admission Screening and Resident Review (PASRR). Finally, all evaluation and contract 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 Mental Health Services and Contracts Section will have 10.0 FTE's.

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), the injection drug use program, and HIV prevention. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) will be administered from the Substance Abuse Services Section. The Substance Abuse Prevention and Treatment State Plan (SAPTBG application) 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 Substance Abuse Services and Contracts Section will have 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 15.9 FTE's. The Women, 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/AODA focus and will strengthen a new integrated MH/AODA approach.

The Women, Youth, and Families Unit addresses the special needs of children, women, 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 Kids First Initiative. An example of a program in the unit is the Urban/Rural Women's AODA Treatment Project, which serves women with substance abuse disorders or co-occurring mental health and substance abuse disorders. Since some women in the program have histories of trauma and abuse, safety plans are developed for every family to address all aspects of the individual's living situation and ensure a safe home environment. 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/AODA 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 programming, and programs to benefit infants such as the Fetal Alcohol Syndrome trainings and the Infant Mental Health Initiative. Unit staff also implements and monitors the new CCS benefit, providing clinical consultation services for consumers with substance abuse and/or mental health disorders, agencies providing services and monitoring child and family advocacy activities. The Women, Youth, and Families Unit has a total of 6 FTE's.

The Systems Transformation 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/AODA Transformation Initiative with a focus on integrated MH/AODA 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 Task Force. Unit staff also be 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. Finally, responsibilities for monitoring CSPs for adults with severe and persistent mental illness reside in the Systems Transformation Unit as well as programs that target housing and coordinating with the Department of Commerce on homeless issues, particularly PATH. The Systems Transformation Unit has a total of 9 FTE's.

Contract Support

In addition to DMHSAS staff, the DMHSAS also relies on contract support with the University of Wisconsin and other agencies to perform unique or specialized tasks. The DMHSAS uses MHBG funds to contract with the Wisconsin Council on Children and Families (WCCF) to set up a children's mental health and a crisis conference annually. The DMHSAS also funds a contractor to provide technical assistance to developing CCS programs and for training coordination, as well as trauma and recovery coordination. Other non-MHBG funded contracts have responsibilities in FFY 2007, including programming for human service disaster preparedness, the development of a Home and Community-Based Waiver program, and revising the administrative rule for outpatient mental health services. In FFY 2008, the DMHSAS intends to continue to contract for two or more university employees to assist with mental health evaluation, trauma and Recovery implementation, and to provide technical assistance to CCS programs.

Training Opportunities and Conferences

Wisconsin will continue to offer cross-disability training at upcoming Department-sponsored conferences. The trauma training curriculum defines a trauma framework emphasizing connection and collaboration between providers, advocates and survivors, as well as respect and empowerment for survivor clients.

The DMHSAS will continue to sponsor an annual Mental Health and Substance Abuse Training Conference to promote cross-training and education of providers on topics such as evidence-based practices and services for persons with co-occurring disorders. Additional annual conferences the DMHSAS helps support include, but are not limited to:

- Children Come First (CCF) Conference,
- Consumer Conference,
- Crisis Intervention Conference, and
- Tribal Affairs Conference.

Training of Providers of Emergency Health Services for Mental Health

There are several ways that Wisconsin is raising community awareness about mental health crisis services. These include local, regional and statewide training. It also includes some very innovative and grassroots involvement that will lead to increased awareness of mental health issues and the connection of these issues to crisis services.

There are some concrete examples of direct training that have been, or will be, offered to first responders. In Appleton, there was a successful Crisis Intervention Team training for law enforcement that was provided by state, county, and private providers to train law enforcement to become local resources for a first response to community members in crisis. These officers, who came from four different counties, will then be better prepared to evaluate people (as a first responder) and to connect people in need to a crisis service. Trainings for law enforcement personnel will continue in FFY 2008.

In North Central Wisconsin, there was a "Question, Persuade, and Refer" training offered to community members including clergy, school personnel, law enforcement, social services staff, community members, consumers, and family members. This training enabled the participants to provide in laymen terms ways to identify people at risk for suicide, individuals with mental health issues, including how to approach them and how to connect them with services. The training will be made available to other agencies including law enforcement, local hospital emergency rooms, fire departments, schools, local physician groups, and other agencies or groups that request it in FFY 2008.

The state has also provided funding and technical assistance to counties to develop certified crisis programs and to develop regional approaches for crisis intervention in FFY 2007. One regional program is training an estimated 200 officers on crisis intervention. Each program that becomes certified is required to have a Community Advisory Group. This group is charged with helping to identify the local needs which can and does include education and awareness of community providers (including first responders) on how to respond to crisis. The development of these regional crisis programs will continue in FFY 2008.

Technical Assistance, Training and Workforce Development for Providers and Consumers

One major area of training offered to mental health service providers and consumers every year is on the principles and implementation of Recovery. The DMHSAS will continue to train consumers to partner with others to provide basic Recovery training. The DMHSAS efforts are geared primarily to our partners

in the transformation efforts who include applicant and certified Comprehensive Community Services (CCS) as well as Community Support Program (CSP) county staff as well as interested and involved consumers at the local level. The Statewide Recovery Implementation Task Force (RTF) continues to provide feedback and direction to Recovery training efforts. Internally, this effort is headed up by the individual in the newly created position of "Recovery Services Coordinator." This position is responsible for coordination and dissemination of information regarding Recovery training and implementation efforts in the state of Wisconsin. This position works with both providers and consumers to promote and disseminate the concepts of Recovery within the state. In development currently is a technical assistance tool kit on the implementation of Recovery concepts in a system. This position will be actively providing technical assistance to counties, providers, and consumer groups where they are working on system transformation efforts in multiple arenas.

The Wisconsin Council on Children and Families will provide technical assistance and training for providers of the 18 ISPs which follow system of care principles to serve children with SED. Non-ISP counties that are interested in phasing in integrated services for children with SED can also attend all training events. The annual Children Come First Conference is designed to increase knowledge and share information with the personnel that work with children in the ISPs and consumers and families. Providers and parents from all areas of the state attend the two-day conference and gain knowledge of the philosophy, implementation, and techniques of the system of care and wraparound. Regional training sessions are also offered to respond to the needs of a specific county or set of counties and tribes. Counties may request training on a particular topic such as team building, how to find natural supports for families, how to work with families in partnership or other relevant topics. The training topics are driven by the providers' needs. All ISPs in the state are invited, but the attendance is usually from counties in the region. In addition, two one-day statewide meetings, and two one-day regional (5 regions) meetings for ISP Project Directors are held each year to share knowledge of the critical issues that all ISPs have in common regarding the provision of services to children with SED.

Training is also provided by DMHSAS contractors on dealing with women's trauma due to physical abuse, sexual abuse, and other sources of trauma. Providers will continue to be trained FFY 2007 on how to identify and treat women's trauma based on a curriculum that was developed in FFY 2004. A trauma summit was held in June of 2007 to promulgate policies for DMHSAS in trauma informed treatment. In a related initiative, Disability Rights of Wisconsin staff provide informational trainings on the intersection between mental illness and domestic violence to service providers where needed throughout the state.

The DMHSAS also funds through a contract with the University of Wisconsin an annual Mental Health Teleconference Series. The Teleconference Series will sponsor and produce 23 biweekly mental health teleconference training sessions for providers of mental health services throughout the state. Mental health service providers from over 80 towns and cities participated in FFY 2005. Over 400 sites have registered for the Teleconference Series. The Teleconference Series provided 2438 credit hours of training for FFY 2005. The average number of persons on each teleconference was 106 and the evaluation scores averaged 3.43 on a 4.0 point scale (4.0 = excellent or strongly agree). The topics presented included Benefits of Work, Family Psychoeducation, Cognitive Behavioral Therapy, Dual Diagnosis, Pain and Depression, Motivational Interviewing, Crisis Intervention, Recovery Principles in Action, Liability, and Post Traumatic Stress Disorder (PTSD) and Adult Trauma.

Financial Management: Fiscal Context of Wisconsin Community Mental Health Services

Financial management of public mental health services occurs within the DHFS and is overseen by the Division of Enterprise Services (DES) and the Office of Policy Initiatives and Budget (OPIB). Within DES are various financial management functions, including accounting, purchasing, and information systems. The OPIB is responsible for budgeting. And 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 DHFS; and the Community Aids Reporting System (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, nonprofit vendors for targeted purposes. The Block Grant funds are specifically identified in the contracts for the given service 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 either quarterly, six-month or annual reports on their progress. Future plans for the DMHSAS' contracting practices in FFY 2008 include the standardization of contract outcome data so it can be aggregated across contracts and all DMHSAS contract outcomes can be examined together. 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. There are no routine fiscal monitoring visits to provider locations. The DMHSAS staff monitors quarterly and semi-annual reports, which provide the basis for identifying and addressing given issues and outcome attainment. Vendors for contracts over \$25,000 are required to undergo an annual audit from an auditor of their choosing and the results are submitted to the DES. The DMHSAS contract monitors work with the 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 and grant funds (MHBG), represents 47 percent of the funding. The state provides funding for services mandated and essential for a community-based service system. 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 MA 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. The majority of MA funds are used for inpatient and institutional facilities, while the majority of GPR and block grant funds are used for community/residential services. 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 2004, counties contributed a reported \$344,423,146 for mental health services.

In addition to the MHBG funding, Wisconsin receives other federal funding to support the mental health service system. The PATH grant for \$640,000 will be used to support mental health services for

individuals who are homeless in four of Wisconsin's largest urban areas. An additional \$72,000 in state funds will be 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 BMHSAS' capacity for data collection and reporting for the MHBG and other programmatic needs. The number of clients served in CSPs is maximized by providing \$1,000,000 of state funds for 21 counties to use as Medicaid non-federal share funding. Another \$1,270,000 of MA funds will be used for PASRR screening activities throughout the state. One million of state General Purpose Revenue is used to fund Crisis Program development and the expansion of CST through the Hospital Diversion Program for children with SED. There are numerous other programs funded with state dollars or other non-MHBG funding sources, but the programs listed above provide an overview of some of the major programs.

For the DMHSAS operations, a total of approximately \$360,969 from the MHBG will provide funding for 5.9 FTE's within the DMHSAS. Another \$864,713, divided between MA and State revenues, will support 10.70 FTE's and, \$164,795, from the Social Services Block Grant, will fund 2.30 FTE's. \$1,505,002 combined from the SAPTBG and the state-funded Drug Abuse Program Improvement Surcharge will fund 19.60 FTE's. In addition, funding from federal grants, Access to Recovery – Wiser Choice and Wisconsin State Epidemiological Outcomes Workgroup Grant will provide funding of \$130,468 for 1.70 FTE's. In FFY 2007, there were three resignations balanced by the hiring of three staff. The position filled was for a Human Services Program Coordinator for substance abuse service rule/regulation interpretation, the Social Services Supervisor and the Mental Health Block Grant Planner. There are 2.0 FTE's vacant with plans to fill all positions. The vacant positions include a Human Services Supervisor and a Substance Abuse Grant Planner/Coordinator.

Medicaid Funding

Wisconsin has a strong track record in the design and management of Medicaid managed care programs, innovative demonstrations, and long-term care waiver programs. DHFS is the state Medicaid agency. Health and long-term care represent over 80 percent of the Department's Medicaid budget. Persons on Supplemental Security Income (SSI) automatically qualify for Medicaid services. The strengths of the Medicaid program are:

- covers a wide range of mental health services,
- has funded a range of mental health medications,
- has proposed an increase in reimbursement rates for outpatient services rates that had been extremely low and were a barrier to provider participation,
- CSP (ACT Program) in the State Medicaid Plan,
- CCS benefit provides reimbursement for community psychosocial rehabilitation services, and
- availability of MAPP for individuals with disabilities who return to work and are no longer eligible for MA.

The weakness of the Medicaid program is that there is a shortage of providers who will supply health care to low-income and Medicaid populations.

Data, Evaluation, and Information Technology Systems

The Human Services Reporting System (HSRS)

HSRS is the primary information system used by DHFS to collect client-specific data on county-provided or -purchased services and has been in operation since 1987. The HSRS tabulates the data to meet a large variety of state and federal reporting needs and meets some county needs as well. The HSRS records client demographic, service, and fiscal data on nearly 400,000 clients.

The HSRS contains a core module used for recording a small number of basic data elements (i.e., name, birth date, sex, ethnicity, target group) describing clients and the social and mental health services they receive through county human service agencies. The HSRS also has eight modules for recording data on specific human service populations such as persons with a mental illness, alcohol or other substance use disorder, people with developmental disabilities, delinquents and status offenders, and the elderly. The HSRS data is used as the basic source of information to meet state and federal reporting requirements and to answer numerous data requests from a variety of federal officials, state staff, legislators, advocacy groups and consumer groups.

The Mental Health Module of HSRS contains three components: consumer demographics, encounter, and consumer status. Data from the Mental Health Module is used to complete many of the federally-required Basic and Developmental Tables and will be used to report on some of the National Outcome Measures as well. Consumer demographics include name, gender, race, ethnicity, date of birth, and mental health descriptive information such as DSM-IV diagnostic impression, presenting problems, overall human service needs, and commitment status. The encounter component includes the types of services received, service units, service dates, and service closing reason. Encounter data elements are updated as changes occur. The third component, called the Consumer Status Data Set (CSDS), was implemented in 2002 to record consumer status for children with SED and adults with a serious mental illness (SMI). The CSDS is a set of twelve data elements including residential status, employment status, daily activities, criminal justice system involvement, suicide risk, and health status. Data for this subpopulation of consumers must be collected every six months to track changes over time as long as consumers are still receiving services. No data collection is required after consumers are discharged.

Data Infrastructure Grant and the MH/AODA Data Warehouse

Wisconsin received funding from the Center for Mental Health Services for a three-year Data Infrastructure Grant (DIG) from FFY 2005-2007 for \$142,200 per year. Wisconsin is developing the data infrastructure necessary to meet the requirements of the MHBG Application and the Health Insurance Portability and Accountability Act. The purpose of Wisconsin's State Mental Health Data Infrastructure Grant project is to enable the State Mental Health Authority (SMHA) to plan more effective mental health services for Wisconsin consumers. Wisconsin employs a data warehouse approach to linking the county-based HSRS descriptive and outcome data, Medicaid data, and other data sets available for decision-making. Both mental health and substance abuse data are integrated into the warehouse to provide for the evaluation of services for persons with co-occurring MH/AODA disorders. The DMHSAS is preparing to move to a web-based information system in the next three years supported in part by funding from the DIG.

By linking multiple data sets together in the data warehouse, we will maximize our ability to report on all consumers served in the SMHA system because no current database adequately serves this purpose. 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. The linking of data and the standardization of evaluation reports should systematically integrate data into Wisconsin's mental health program and policy decision-making process. The primary goal is to build Wisconsin's reporting capacity to complete all of the Uniform Reporting System Data Tables required by the MHBG. Currently, Wisconsin is able to complete the 12 Basic Tables, but is proposing to increase its capacity to report on the 9 Developmental Tables with this new grant.

Finally, Wisconsin plans to learn from other state initiatives to incorporate web-based technology to implement its own web-based system. The system would streamline the data submission process for counties and would allow them to have access to both standardized and ad hoc data reports for their decision-making processes.

MH/AODA Transformation Data Needs

For FFY 2008 plans for the Recovery Oriented System Tool (ROSA) developed by Wisconsin to measure consumer outcomes is primarily to implement a modified ROSA model called the “ROSA Front-End Project.” This project uses the ROSA instrument as a tool to review intake and assessment processes and forms to ensure they are Recovery-oriented. The Recovery principles and consumer outcomes defined in the ROSA interview instrument are reviewed for their presence in the intake and assessment process. Technical assistance is being provided to counties on how to conduct a “ROSA Front-End Project” and consumers are involved in the process as well. This modified implementation process gives counties a quicker option to start implementing Recovery principles, but does not preclude the more intensive use of the ROSA interview.

Wisconsin also developed a MH/Substance Abuse Functional Screen which is designed to assess a consumer’s level of service need. The screen includes a variety of clinical and functional data elements that providers are required to submit. The screen has been designed as a web-based application for ease of use by the provider and the provision of quick screening results. The screen is primarily for mental health consumers, but can also be used for consumers with co-occurring MH/Substance Abuse disorders. For consumers who may have a primary substance abuse diagnosis, the MH/Substance Abuse Functional Screen is linked to another substance abuse screening tool that providers can also use. The plan for the use of the Functional Screen in FFY 2008 is to continue to disseminate its use throughout the state to further standardize the determination of need for services for mental health consumers. The screen is currently being required for the CCS and COP programs in Wisconsin. The staff encourages its use to determine need for CSP services. Data from the MH/Substance Abuse Functional Screen will be imported into the MH/Substance Abuse data warehouse so it can be linked to other mental health data sets and analyzed for results.

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 HFS 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 HFS 34. Crisis program staff training records are maintained locally and are reviewed by the state DHFS/Division of Quality Assurance when certifying and re-certifying crisis programs. Currently almost all counties are certified for basic emergency crisis services, and 40 counties are certified under HFS 34 Subchapter III standards for emergency service programs. These programs are eligible for MA or third-party reimbursement. Over the next two years, there will be at least 45 crisis programs certified under HFS 34 Subchapter III.

The Crisis Intervention Network

The Crisis Intervention Network, numbering 177 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 will be 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. A Peer Specialist training was also held for Milwaukee/Waukesha to aid in the development of their crisis program. Local savings from reduced hospital/institutional placements along with the Medicaid reimbursements would help to sustain the programs. Of the 30 counties involved in the six Regional Multi-County Crisis Programs, 26 are certified HFS 34 Subchapter III and six more will become certified within two years.

Crisis Intervention Conference

The 11th Annual Crisis Intervention Conference will occur in September 2007. It is 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 3 years has been 500 - 600 participants. Conference hours apply to required on-going training for individuals providing certified mental health crisis services under HFS 34. Other required crisis training opportunities include supervision, consultation, and backup are provided independently by each certified crisis program according to the standards set forth in HFS 34.

Expenditure Plan for Block Grant Funds for FFY 2008

At the time of the writing of this application, Wisconsin had not yet been notified by CMHS of its grant award for FFY 2008. The expenditure plan below for FFY 2008-2009 is based on the FFY 2007 award amount.

FFY 2008 MHBG Budget

\$2,513,400 County Formula Allocation

This allocation is designated to county mental health agencies to fund additional programs for persons with serious mental illness. The DHFS 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, urban/rural designation, and population (see Schedule I for the projected 2008 allocation for each county). Each agency will use the funds for one or more of the following eight priority areas:

- certified CSP 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, and
- mental health outcome data system improvement.

Within these eight priority areas, counties will be asked to prioritize serving persons with a serious mental illness who are homeless either through immediate action or priority placement on a wait list. The state requires counties to submit reports detailing how they plan to use future funds and how they spent funds from previous years. Specific contracts are developed with each agency to assure oversight and compliance.

\$1,826,500 Children's Initiatives - ISP and CST

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 and tribal projects the capacity to provide the flexibility needed by both children/adolescents and their families. In addition, the grant may fund clinical positions to directly coordinate integrated services within an ISP. 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 a strengths-based coordinated system of care that supports children and adolescents and their families who require substance abuse, mental health, juvenile justice, and/or child welfare services.

\$874,000 Family/Consumer Self-Help and Peer to Peer Support Programs

While some other states do not directly fund consumer self-help and support services at all, Wisconsin is proud to have a tradition of using its MHBG for this purpose. Wisconsin will continue to fund consumer self-help and peer support programs with the same aggregate level of funding. 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.

\$1,008,898 Transformation Activities

Wisconsin is putting substantial resources into transformation activities. For FFY 2008, a key transformation activity will be to work with state partners, counties, tribes, consumers and advocacy groups to review and plan for a further transformation of the county-based services system. Efforts will also continue to implement quality improvement projects and evidence-based practices in their CCS or

CSP programs. These grants are designed to integrate evidence-based practices with Wisconsin's major mental health programs and establish permanent quality improvement systems so counties can continually review the quality and effectiveness of their programs. We are funding pilots for coordination of the mental health system with the child welfare system to integrate mental health screening into child welfare procedures. Wisconsin is addressing the lack of specialty mental health providers in rural parts of the state by the development of a consultation service. We are collaborating with the Department of Commerce to provide assertive outreach to homeless individuals with mental illness. Finally we are allocating funds for implementation of culturally appropriate best practices in the eleven tribes.

\$441,971 Systems Change

The Systems Change funds will focus heavily on prevention and implementing Recovery principles. Much of our work is with children. We will be collaborating with the Mental Health Association, and the Department of Public Instruction on suicide prevention in middle schools. We provide support to a child and family advocacy agency to make advocacy and self-advocacy services available for children's programs like CCS, CST, and ISP's. We have a contract with the University to work with counties on implementation of a Recovery-based approach to service delivery. This contract also uses a train the trainer model to develop a pool of consumers who will provide statewide training to other consumers.

\$147,042 Training and Technical Assistance

Training funds will be contracted to improve provider knowledge and skills in mental health standards, best practice, recovery principles, and emergency crisis services for statewide system delivery for consumers of all ages.

- statewide teleconferences and integrated annual conference on MH/SA clinical training topics,
- geropsychiatry training and stipends for elderly consumer participation,
- state conferences on children's and adult's mental health services and crisis services, and
- consumer/family stipends and expenses to facilitate their participation in statewide mental health planning and policy meetings.

\$65,000 Wisconsin Protection and Advocacy

Disability Rights Wisconsin is the designated agency within the state to provide protection and advocacy for persons with mental illness.

\$360,968 State MH Authority Staff – Planning and Technical Assistance.

The DMHSAS staff (5.9 FTEs) who work in the mental health field will be funded through the MHBG. Staff plan services, provide technical assistance to local mental health providers and programs in the implementation of programs.

\$300,796 Administrative/State Operation Costs

These funds cover the costs of the Mental Health Council, accounting, mental health HSRS data collection, and indirect costs of administering the grant. (Data System development will utilize \$111,615 of these funds.)

\$7,538,575 TOTAL

In compliance with block grant instructions Section 1942, the following table describes how the Mental Health Block Grant is used to meet the five federal criteria.

Table 16
Summary of Plan for FFY 2007-08 Community Mental Health
Services Block Grant Funds

Program	FFY 2007	FFY 2008	Federal Criterion
County Formula Allocation	\$2,513,400	\$2,513,400	I, II, III, IV, V
Children's Initiatives-ISP and CST	1,826,500	1,826,500	III
Family/Consumer Self-Help & Peer Support	874,000	874,000	I, III, IV, V
Transformation Activities	895,196	1,008,898	I, II, III, IV, V
Systems Change	495,945	441,971	I, II, III, IV, V
Training and Technical Assistance	172,799	147,042	I, II, III, IV, V
Wisconsin Protection & Advocacy	65,000	65,000	I
State MH Authority Staff-Planning & Technical Assistance	300,034	360,968	I, II, III, IV, V
Administration/State Operations	221,730	300,796	I, III, V
Recovery and Prevention/Early Intervention	173,971		
Total	\$7,538,575	\$7,538,575	

Table 17
Wisconsin's Projected County Formula Allocation – CY 2006-2007

<u>County Agency</u>	<u>CY 2006</u>	<u>CY 2007</u>
Adams County Department of Community Programs	8,555	8,555
Ashland County Human Services Department	9,580	9,580
Barron County Human Services Department	20,066	20,066
Bayfield County Department of Community Programs	7,354	7,354
Brown County Department of Human Services	98,340	98,340
Buffalo County Department of Health and Human Services	7,803	7,803
Burnett County Department of Health and Human Services	7,248	7,248
Calumet County Department of Human Services	12,388	12,388
Chippewa County Department of Human Services	27,037	27,037
Clark County Community Services	16,032	16,032
Columbia County Human Services Department	16,818	16,818
Crawford County Human Services Department	7,939	7,939
Dane County Department of Human Services	160,098	160,098
Dodge County Human Services and Health Department	31,007	31,007
Door County Department of Community Programs	7,665	7,665
Douglas County Human Services	25,572	25,572
Dunn County Department of Human Services	18,754	18,754
Eau Claire County Department of Human Services	51,569	51,569
Florence County Human Services Department	3,434	3,434
Fond du Lac Department of Community Programs	37,307	37,307
Forest, Oneida, Vilas, Human Services Center	24,615	24,615
Grant-Iowa Unified Board	30,080	30,080
Green County Human Services	11,554	11,554
Green Lake County Health and Human Services Department	6,805	6,805
Iron County Department of Human Services	3,621	3,621
Jackson County Department of Health and Human Services	8,922	8,922
Jefferson County Human Service Department	26,128	26,128
Juneau County Department of Human Services	10,820	10,820
Kenosha County Department of Human Services	72,813	72,813
Kewaunee County Department of Human Services	7,486	7,486
La Crosse County Human Services Department	56,779	56,779
Lafayette County Human Services	7,785	7,785
North Central Community Services Program	71,892	71,892
Manitowoc County Human Services Department	35,127	35,127
Marinette County Health and Human Services Department	18,732	18,732
Marquette County Unified Services Board	6,423	6,423
Menominee County Health and Human Services Department	5,752	5,752
Milwaukee County Department of Human Services	685,914	685,914
Monroe County Department of Human Services	18,307	18,307
Oconto County Department of Human Services	13,353	13,353
Outagamie County Department of Human Services	64,126	64,126
Ozaukee County Department of Community Programs	25,233	25,233
Pepin County Department of Human Services	4,795	4,795
Pierce County Department of Human Services	13,239	13,239
Polk County Human Services Department	17,164	17,164
Portage County Health and Human Services Department	25,490	25,490
Price County Human Services Department	8,029	8,029
Racine County Human Services Department	100,488	100,488
Richland County Community Programs	9,465	9,465

<u>County Agency</u>	<u>CY 2006</u>	<u>CY 2007</u>
Rock County Human Services Department	73,312	73,312
Rusk County Health and Human Services Department	9,661	9,661
Sauk County Department of Human Services	17,541	17,541
Sawyer County Health and Human Services	8,146	8,146
Shawano Department of Community Programs	16,604	16,604
Sheboygan County Health and Human Service Department	51,197	51,197
St Croix County Health and Human Services Department	17,529	17,529
Taylor County Human Services Department	9,043	9,043
Trempealeau County Unified Board	15,769	15,769
Vernon County Department of Human Services	12,392	12,392
Walworth County Department of Health and Human Services	22,005	22,005
Washburn County Human Services Department	8,386	8,386
Washington County Comprehensive Community Services Agency	37,470	37,470
Waukesha County Community Human Services Department	109,469	109,469
Waupaca County Department of Human Services	20,786	20,786
Waushara County Department of Community Programs	10,433	10,433
Winnebago County Department of Community Programs	68,961	68,961
Wood County Unified Services	<u>39,193</u>	<u>39,193</u>
TOTAL	<u>2,513,400</u>	<u>2,513,400</u>

**STATE PLAN PERFORMANCE INDICATOR
FFY 2008**

Criterion 5

Goal 1:	At least maintain resources to consumer-run programs and services and to family support services.
Objective:	Maintain funding for consumer and family programs and services in FFY 2008.
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 2008.
Measure:	<i>Numerator:</i> FFY 2008 funds allocated to consumer-run and family support programs subtracted from FFY 2007 funds allocated to consumer-run and family support programs. <i>Denominator:</i> FFY 2007 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 funding levels for consumer and family support services in FFY 2008. 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.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: FFY 2008

Population: Adults with SMI

Criterion: Management Systems

Performance Indicator:					
Resources for consumer support programs	FFY 2004 Actual	FFY 2005 Actual	FFY 2006 Actual	FFY 2007 Actual	FFY 2008 Target
Value:	0% change	0% change	0% change	3.2% change	0% change
Numerator:	\$874,000- 874,000	\$874,000- 874,000	\$874,000- 874,000	\$902,000- 874,000	\$902,000- 902,000
Denominator:	\$874,000	\$874,000	\$874,000	\$874,000	\$902,000

Note 1: Data is reported in FFY periods for the purpose of this report, but actually is from CY periods because contracts for consumer support programs are issued on a calendar year basis. FFY 2008 expenditures are for CY 2008, etc.

Action Plan

The plan for FFY 2007 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. The agencies selected to receive funding in FFY 2007 will be funded again in FFY 2008 to provide services in the same areas of adult consumer support, adult and family consumer support, and child and family support.