Building on a Strong Foundation

The State of Wisconsin's Mental Health System

Wisconsin Council on Mental Health

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The Wisconsin Council on Mental Health

Promoting Mental Health in Wisconsin Through Hope, Awareness, and Recovery

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Introduction

In the area of services for the treatment of persons with mental illness, as in so many areas of social and human services, Wisconsin has truly been an incubator for the nation. Community support program (CSP) services were developed in Madison, through a program of the Mendota Mental Health Institute: PACT—the Program for Assertive Community Treatment. This program has been shown through rigorous research to improve outcomes for adults with mental illness. Similarly, WrapAround Milwaukee has pioneered the use of managed care techniques to serve the complex needs of youth with serious emotional disturbance who may also be involved in the juvenile justice system, child welfare or have substance abuse disorders. WrapAround Milwaukee was cited as a model program in the Surgeon General's Report on Mental Health.

> *"We know a great deal about how to effectively treat mental illness. What we need to do is make these services more widely available."*
>
> Les Higgenbottom, Chair
> Wisconsin Council on Mental Health

And yet these proven interventions, developed in Wisconsin and copied across the country, along with other promising practices, are not available to all Wisconsin residents who may be able to benefit from them. The reasons are varied and will be addressed throughout this report. However, to a significant degree we find that inequities in how mental health services are treated are handicapping the delivery of mental health treatment:

- CSP services are covered inequitably under the Wisconsin Medicaid program. While the State and Federal governments pay the cost of most Medicaid services, county or tribal governments must pay the state share of the CSP services. This has resulted in waiting lists in many areas of the state.
- While Wisconsin Medicaid pays the full cost of inpatient hospital treatment for youth with serious emotional disturbance, many of the services that would keep these youth safely in the community are not covered. Additionally, while the state has utilized federal block grant dollars to support the development of wraparound programs in about half of Wisconsin's counties, the rest remain without such programs and the state has failed to adequately invest any of its own dollars to support these programs.
- State statutes continue to allow private health insurance to limit coverage of mental illness and substance abuse disorders to $7000 per year—enough for no more than 14 days of inpatient hospital treatment.

Such inequities might not be a concern if they didn't make a difference. However, the consequences of failing to provide adequate treatment services are serious:

- 16-18% of individuals in jails and prisons have a mental illness.
- 20-25% of the single adult homeless population has a serious mental illness.
- Children with serious emotional disturbances have the lowest high school completion rate among children with disabilities.
- A Michigan study found that 35% of women on public assistance met criteria for a mental disorder.
- 588 people died from suicide in Wisconsin in 2000, three times the number that died from homicide. Suicide is the third leading cause of death for young people aged 15-24; suicide rates are highest for people age 65 and older. 90% of suicides are associated with a mental illness.

This report does not attempt to provide a comprehensive overview of mental illness and its treatment in Wisconsin. Readers will want to refer to the Legislative Fiscal Bureau's report, *Services for Persons with Mental Illness,* for an overview of Wisconsin's mental health system and funding. The Surgeon General's *Report on Mental Health* is a compendium of what we know about mental illness and its treatment.

What this report does try to do is focus on those areas where the Wisconsin Council on Mental Health believes the Governor, Legislature and Department of Health and Family Services can most effectively impact those most in need. We do so through the following:

Trends and Overriding Issues: A brief review of some of the key trends impacting the mental health system and emergent and overriding issues that influence our response to mental illness.

Programmatic Recommendations: Identification of the strengths and weaknesses in selected priority areas with specific recommendations on how to improve them.

Service Snapshots: Snapshots of successful programs and services—the foundation on which we seek to build. These snapshots describe the program and the identified outcomes, where those are available.

The take-away message is simple: we know a great deal about how to effectively treat mental illness. What we need to do is to make these services more widely available.

Building on a Strong Foundation:

Key Recommendations

The Wisconsin Council on Mental Health (WCMH) believes that the Governor and Legislature can and should continue to build on the solid foundation that has been developed for public and private mental health services. The following are our major recommendations. Some of these require no state funding to implement and others require only modest investments. Many of these can be implemented incrementally as they have been to date. These are not budget proposals—WCMH continues work on specific proposals for the 2003-2005 biennial budget—but rather the blueprint for continuing to improve mental health services in Wisconsin.

- Supporting the continued development of the mental health/alcohol and other drug abuse redesign initiative, including continued or increased funding for recovery, consumer and family support, and prevention/early intervention activities.
- Investing State dollars in expansion of wraparound services for youth with serious emotional disorders to all counties.
- Ensuring that all individuals who qualify for and want mental health services covered under the Wisconsin Medicaid program have timely access to these services by:

  - ✓ Implementing the Comprehensive Community Services benefit.
  - ✓ Maintaining an open formulary for mental health drugs and severely limiting the use of prior authorization for these products.
  - ✓ Exploring additional options for Medicaid coverage of mental health services. Targeted use of local matching funds and home and community based waivers can allow this to happen with little cost in state GPR.
  - ✓ Providing the state share of funding for Medicaid benefits that currently require county match.
- Piloting an expansion of the conditional release program to support successful reintegration of offenders with mental illness into the community.
- Expanding Senior Care to the non-elderly disabled population covered by Medicare.
- Enacting legislation that ensures parity for mental health and substance abuse treatment services in commercial health insurance plans.

The Wisconsin Council on Mental Health

Council Membership and Duties

The Wisconsin Council on Mental Health (WCMH) consists of 15 members, at least half of whom must be mental health consumers or other persons who are not state employees or mental health providers. The members are appointed by the Governor (see inside back cover for a list of current WCMH members). Among the duties of the Council, as authorized under s. 51.02 Wis. Stats. are to:

- Advise the department, the Legislature and the Governor on the use of state and federal resources and on the provision and administration of programs for persons who are mentally ill or who have other mental health problems.

- Provide recommendations to the department on the expenditure of federal funds received under the community mental health block grant.

- Serve as an advocate for persons with mental illness.

- Promote the development and administration of a delivery system for community mental health services that is sensitive to the needs of consumers of the services.

In addition, the Council is permitted to submit annually a report on recommended policy changes in the area of mental health to the Governor, Legislature and Secretary of the Department of Health and Family Services.

Council Committees

The Council does a significant amount of its work through four standing committees and issue focused sub-committees. In addition to the Executive and Nominating Committees the standing committees and their duties are:

- *Public Awareness*: promoting statewide dissemination of information on mental health and mental illness.
- *Planning and Monitoring*: review and monitor the mental health system's progress toward achieving improved client outcomes and effective service delivery.
- *Legislative and Policy*: monitoring legislative activities and making recommendations to the Council on policy issues.

The Council currently has two sub-committees:

- *Children's Issues:* exploring issues that specifically impact children with serious emotional disturbances and their families.
- *Criminal Justice Issues:* working with the Department of Corrections and other key players in the justice system to explore how individuals with mental illness can be diverted from correctional settings, when possible, better served when in jails and prisons and more effectively reintegrated into the community upon release.

Council Priorities

The work of the Council is directed towards the priorities developed during its strategic planning. In addition to the issues addressed in the two subcommittees identified above the Council is also interested in the following:

- Implementation of the recommendations of the Governor's Blue Ribbon Commission on Mental Health.
- Evolution of the MH/AODA redesign process.
- Expansion of consumer-run programs.
- Improving housing options and access for persons with mental illness.
- Implementation of the Olmstead Decision and the ADA Title II plan.
- Mental health and substance abuse insurance parity.

Part 1

Trends and Overriding Issues

Mental Health System Trends

Funding

Almost half of all mental health services—nationally, and in Wisconsin--are funded through Medicaid. What is unique in Wisconsin is the degree to which mental health services are funded through county tax levy. While some 20 states administer public mental health services through sub-state entities few rely on local funding to the degree that Wisconsin does. Wisconsin ranks third (behind only New York and California) in human services spending by local governments at 28.3%.

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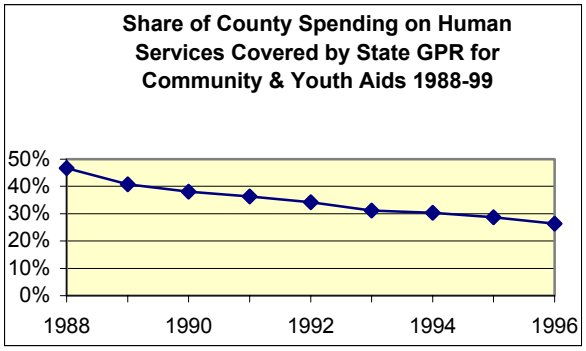
(Governor's Blue Ribbon Commission on State-Local Partnerships)



This is significant in that Community Aids funding has been essentially flat during the 1990s and according to an analysis by the Wisconsin Council on Children and Families has declined 26% in real dollars between 1996 and the current biennium. That same analysis found that the portion of county human service spending funded by Community Aids fell from 46% in 1988 to 26% in 1999 and the GPR share went from 36% to 12%. Counties in turn increased their spending, with their "overmatch" of Community Aids increasing fourfold from 1987 to 1999. Since 1996 the counties annual match and overmatch funding of nearly $250 million has exceeded the State's GPR Community Aids funding of $175 million. This has put a tremendous strain on local governments, which are facing a variety of fiscal pressures.

The Olmstead Decision and Services for Persons with Mental Illness

In 1999 the U.S. Supreme Court, in the case of Olmstead v. L.C., ruled that it was a violation of the Americans with Disabilities Act (ADA) for the state to fail to place two individuals with mental illness into the community after treatment staff determined that it was appropriate for them to be discharged from an institutional setting. The impact of the ruling was not limited to persons with mental illness, but rather to all persons protected under the ADA. The ruling did not require states to immediately move all individuals out of institutions, but the Office of Civil Rights did indicate that states could demonstrate compliance with the law by having a plan for ensuring that individuals who could live in the community would be identified and movement out of institutions would proceed at a reasonable pace.

In 2001 the DHFS formed a committee of advocates, service providers, state employees, and persons with disabilities to develop such a plan for Wisconsin. This plan specifically identified a number of recommendations with regard to persons with mental illness. These included:

- Achieve a full range of long-term care services and supports, including housing, employment, transportation and treatment services.
- The state should assume the state share of funding for CSP services.
- Develop the capacity for all counties to provide community-based services for children with emotional disorders (such as wraparound programs).
- Explore ways for persons with mental illness to be served under existing home and community based waiver programs.

Growing Awareness of Impact of Mental Illness on Other State Programs.

While Olmstead provides a legal impetus for the development and expansion of mental health services, increasingly other public systems are recognizing the impact that untreated or undertreated mental illness have on their programs.

Public Health: The redesign of the public health system, Turning Point, has resulted in mental illness being identified as one of 11 priority health conditions for public health. As a result, a subcommittee identified 4 primary objectives in this area, including addressing stigma around mental illness and enhanced screening for mental illness in public systems. These efforts can enhance early identification of mental disorders.

Aging: In 1999 national estimates suggested as many as 20% of persons over 65 years old need an intervention of some kind in order to address or treat mental health problems. In Wisconsin, about 25% of older adults seeking services through Family Care have been identified as having mental health issues. Suicide rates are highest among individuals over age 65. Older adults are under-identified and underserved when it comes to mental health issues.

Public Instruction: Suicide is the number three cause of death among youth 15-24. According to the Wisconsin 2001 Youth Behavioral Risk Survey, 9% of students have indicated they have contemplated suicide in the past 12 months. The DPI has instituted a major initiative to prevent suicide among youth.

Corrections: A recent LAB audit found that 2,642 inmates (17%) in Wisconsin's correction system have a mental illness. This is consistent with national data that 16-18% of jail and prison inmates have a mental illness. People with mental illness tend to stay in jail longer because of the lack of outside resources. They are vulnerable to being victims of abuse by other inmates and more likely to be in segregation, which can worsen their illness. Inmates with mental illness can also present a safety concern for prisons and jails unequipped to address their special needs.

Emergent Issues in 2002

Suicide Prevention

2002 saw the release of the *Wisconsin Suicide Prevention Strategy*. Based on the *National Strategy for Suicide Prevention* this document lists 11 goals with related objectives and activities that interested persons and organizations can implement in their communities. The *Strategy* uses a public health approach to address these chilling facts:

- The 588 suicides in Wisconsin in 2000 were three times the number of homicides in that same year.
- Suicide is the second leading cause of death among young people age 15-34.
- One in five Wisconsin high school students reported seriously considering suicide.
- Elderly males (over age 75) are three times more likely to commit suicide than the general population.

90% of persons who commit suicide have a mental illness. Many of these suicides are preventable. The *Strategy* provides many concrete examples of ways in which local communities can begin to address this public health problem.

Trauma

Trauma, whether it results from physical or sexual abuse, exposure to violence, or prolonged hardship, can contribute to substance abuse or mental disorders. Trauma impacts individuals across the lifespan, from the abuse that lands children in the child protective services system to elder abuse. A recent study of women who had received mental health and/or substance abuse treatment services in Dane County found that:

- 86% had experienced physical abuse;
- 74% had experienced sexual abuse; and,
- 91% had experienced either physical or sexual abuse.

Understanding that trauma may be a contributor to mental disorders requires that service providers be assessing for a history of trauma, something that does not always occur at this time. It also requires different responses to those seeking help, including providing help with meeting basic needs for income, shelter, employment, health care; and providing more social support from peers, friends, and family.

Understanding the relationship between trauma and mental disorders also allows us to consider ways to intervene with individuals who have experienced trauma to prevent the development of mental disorders. The Governor's Blue Ribbon Commission on Mental Health identified post-traumatic stress disorder as a target for prevention and early intervention activities and this is one of the targets of a statewide initiative.

Stigma

Stigma towards persons with mental illness continues to profoundly impact both the availability of treatment and the willingness of persons to avail themselves of treatment. Despite the acknowledgement by many well-known individuals of their mental illnesses—including Marie Osmond, Mike Wallace, and Lionel Aldridge—mental illness continues to be viewed as something to be ashamed of rather than something to be treated.

> *"Stigma leads to isolation and discourages people from seeking the treatment they need."*
>
> President George W. Bush
> April 28, 2002

In his landmark Report on Mental Health the Surgeon General noted that "Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment" (Chapter 1). Although the public is generally more knowledgeable about mental illness today than it was 30 years ago, fears of violence—which are reinforced by selective media coverage—have contributed to lingering stigma. And yet the Surgeon General concludes that "*there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder*."

While stigma can best be characterized as an attitude or belief, it is also manifested as discrimination. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders. Perhaps the most publicly discussed form of discrimination is that which occurs in commercial health insurance, where coverage for mental illness is generally much less than for other disorders. Unfortunately such stigma further limits access to needed treatments.

Most research now indicates that although education is an important element to combating stigma, it is actual contact with persons with mental illness that can replace the negative stereotypes with positive images of persons with mental illness. Additionally, as the Surgeon General noted, "research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote."

In Wisconsin, a major public/private anti-stigma initiative got underway in 2002. Wisconsin United for Mental Health brings together the state agencies responsible for mental health and public health with a wide variety of mental health consumer, family and advocacy groups. In addition to a developing an informational website (www.wimentalhealth.org), the group has purchased copies of "A Beautiful Mind" for regional library systems, is working on a speaker's bureau, will be sponsoring media roundtables, and working with employers to address mental health issues in the workplace.

Part 2

Programmatic Recommendations

Mental Health/Alcohol and Other Drug Abuse (MH/AODA) Redesign

The strength of Wisconsin's county-based human service system has been the ability of local governments to fashion programs to address local needs. While this has spawned some well-regarded programs, it has also resulted in extreme variability in access to services and types of services available in different parts of the state.

The MH/AODA redesign process addresses this concern. By more clearly identifying what works, through use of consumer outcomes and other quality indicators, and better identifying the costs for services across all payers, the demonstrations set the stage for identifying a cost effective approach to providing services to people with mental illness and co-occurring disorders. The redesign process encompasses intensive activity in four selected demonstration sites, along with statewide initiatives related to recovery, prevention/early intervention, consumer-operated services and family support (see Service Snapshots on pages 22-23). Additionally, wraparound programs for youth with serious emotional disorders have been developed in many counties (see Service Snapshot on page 20).

Strengths of Redesign Process

- Development of consumer outcomes tool and functional screen.
- Implementation of recovery and prevention/early intervention practices.
- Inclusion of consumers and families in planning.
- Development and support of consumer-operated services.

Weaknesses of Redesign Process

- Inadequate investment of state dollars in staffing and services.
- Slow progress of initiative threatens to undermine support.

WCMH RECOMMENDATIONS

1. Support continued development and implementation of consumer outcomes process, functional screen, quality assurance activities, and costs analysis activities that will move the projects towards a Medicaid managed care model.
2. Support continued efforts on behalf of recovery, prevention/early intervention, consumer-operated services and family support.
3. Fund additional staff to support development of the initiative.
4. Invest state dollars in expansion of wraparound services for youth with serious emotional disorders (see Service Snapshot on page 20).
5. Develop a strategic plan about how to better meet the needs of trauma survivors who have mental illnesses and which must minimally include training for service providers about the effects of trauma and effective treatment and support approaches.

Wisconsin Medicaid

As noted earlier, Medicaid is the single largest funder of mental health services in the country. For the most part, Medicaid services are funded jointly by the State and the federal government, with the State paying approximately 40% of the cost of each service. However, for a number of Medicaid benefits, most notably community support program services (see Service Snapshot on page 19), crisis intervention services and targeted case management county or tribal agencies must pay the "state share" of the Medicaid reimbursement. The rationale for this was that counties could use state dollars they received through Community Aids, to meet this match requirement. However, due to declining Community Aids counties and tribes have not been able to provide these services to all eligible Medicaid recipients. At the same time, expansion of Medicaid benefits could increase options for consumers that focus on recovery and also draw additional federal dollars to Wisconsin.

Strengths of Medicaid

- Wisconsin Medicaid provides a wide range of mental health services.
- Wisconsin Medicaid has an open formulary for pharmaceuticals and uses prior authorization sparingly, thus allowing physicians and consumers access to the most effective medications.
- Wisconsin Medicaid recently increased reimbursement rates for outpatient services, rates that had been extremely low and were a barrier to provider participation.
- Availability of Medical Assistance Purchase Plan for individuals with disabilities who return to work and no longer are eligible for Medicaid.

Weaknesses of Medicaid

- Counties and tribes must pay the state share for certain mental health services which results in diminished access to services in some parts of the state.
- Certain options allowable under federal law, such as rehabilitation services in the community, are not available under Wisconsin Medicaid to the extent they could be.

WCMH RECOMMENDATIONS

1. The State should provide the state share of funding for Medicaid benefits that currently require county match.
2. The State should implement the Comprehensive Community Services benefit.
3. The State should explore adding Medicaid benefits to increase flexibility and consumer choice. The State should explore doing so under waivers, through the MH/AODA redesign, or with local match in order to address concerns about cost.
4. The State should maintain an open formulary for mental health drugs and severely limit the use of prior authorization for these products.

Criminal Justice

Available Wisconsin data is consistent with national data with regard to involvement of persons with mental illness in the criminal justice system: about 17% of the prison population has a significant mental illness and 60-80% of youth in the juvenile justice system have at least one diagnosable mental condition. For many individuals these mental disorders are exacerbated by a co-occurring substance abuse disorder.

Persons with mental illness are normally not well served in correctional settings and can create behavior and safety concerns for correctional staff. Many individuals do not pose a threat to community safety if appropriate services are available for diversion. For those who are required to remain in correctional settings it is critical that effective mental health services be available. It is possible to slow down the flow of persons with mental illness and addictive disorders into our corrections system by addressing the mental health treatment needs of adults and youth in our communities before these individuals become offenders. However, even after offense, non-violent offenders can successfully be diverted into treatment programs. It is also important to identify policies and procedures that support successful re-entry to the community and reduce recidivism. This includes ensuring the offenders have timely access to Medicaid, SSI and SSDI upon release and are engaged in community-based treatments and supports as needed.

Strengths in Corrections System

- Hiring of new Mental Health Director who can focus on mental illness treatment needs in the corrections system.
- Existence of specialized mental health and substance abuse treatment programs.
- Efforts to address re-entry issues, e.g., ensuring availability of Medicaid and SSI upon release.
- "Going Home" grant in juvenile corrections.

Weaknesses in Corrections System

- Lack of a statewide screening and assessment tool on entry into the criminal justice system.
- Inadequate opportunities for diversion into effective community-based treatment.
- Inadequate treatment programs/professionals in correctional settings to meet need.
- Lack of specialized programs to support re-entry of persons with serious mental disorders.

WCMH RECOMMENDATIONS

1. Additional funding for community support programs and wraparound programs that can serve as diversions options (see Service Snapshots on pages 19 and 20).
2. Expand mental health treatment staff and programs in correctional settings.
3. Pilot an expansion of the conditional release program to support successful reintegration of offenders with mental illness into the community (see Service Snapshot on page 21).

Mental Health and Substance Abuse Parity

Parity in health insurance means that coverage of treatment for mental illness and substance abuse disorders is no more restrictive than coverage for other medical conditions. Currently Wisconsin statutes require a minimum mandated benefit for mental health and substance abuse disorders of $7,000 per year (with an adjustment for copayments). Within this, a minimum of $2,000 is allowed for outpatient treatment and $3,000 for transitional treatment services (such as residential treatment services) if the $7,000 is not otherwise expended.

While the majority of individuals covered by group health insurance plans impacted by these requirements will not come close to exceeding these minimums, the consequences for those who do are considerable. Families may have to sell a home or declare bankruptcy to deal with the costs associated with extended inpatient hospital stays when those are required. With average inpatient costs at $500/day in Wisconsin, the current benefit allows only 14 days of hospital treatment. Indeed, a study cited in the Surgeon General's *Report on Mental Health* found that individuals incurring $35,000 in mental health treatment costs would pay, on average, $11,800 out of pocket. Individuals incurring the same level of costs for other medical treatments would pay about $1500 out of pocket.

The lack of parity may be especially burdensome for families who have a child requiring treatment. Because of the challenges of managing children with serious emotional disturbances and the difficulties in diagnosis, longer inpatient hospital stays are often required. Adding to the cost burden is the fact that some families end up giving up custody of their children in order to access treatment services that can be funded through Medicaid or through county-based human services. Ultimately, this shifts costs from the private sector to the public sector.

Federal law currently requires businesses with 50 or more employees to ensure that annual and lifetime dollar limits on mental health services (not substance abuse) are no more restrictive than such limits for other medical care. However, health plans can, and do, still impose more restrictive day or visit limits or copayments.

The current $7,000 mandated minimum was created in 1985 and this dollar amount has not been updated since that time. A Legislative Council Study Committee recently recommended increasing the mandated minimums to reflect increases in medical cost inflation since the mandates were introduced.

WCMH RECOMMENDATION

- Pass legislation that eliminates more restrictive health insurance coverage for mental illness and substance abuse disorders.

Cross-Disability Issues

While some issues, like parity, disproportionately impact persons with mental illness, there are other issues that are common to many persons with various types of disabilities.

Access to Medications: SeniorCare addressed the needs of older adults who do not have prescription drug coverage. However, many non-elderly persons with disabilities are on Medicare or are uninsured. These individuals tend to be poorer than older adults and have higher medication costs, yet they have less access to medications. About a third of the non-elderly disabled persons on Medicare have a mental disorder. Timely access to medications can save money in the future by reducing the number of individuals who ultimately qualify for Medicaid due to institutionalization.

Dental Services: Access to dental services, especially through the Wisconsin Medicaid program continues to be a major issue for persons with disabilities. In many communities it is not possible to find a dentist who is taking new Medicaid patients. This is a particular concern for individuals with mental illness because many of the medications they take cause dry mouth, which increases risk for many dental diseases. In 2000, a Legislative Council Study Committee made a number of recommendations to improve dental care access. These included such initiatives as increasing Medicaid reimbursement rates for dental services, funding dental health professionals through public health, expanding the practice settings and circumstances for dental hygienists, and increasing tuition assistance for students at the Marquette University School of Dentistry.

Housing: A national report entitled "Priced Out in 2000—The Crisis Continues," published by the Technical Assistance Collaborative, Inc. of Boston, and the Consortium for Citizens with Disabilities Housing Task Force of Washington D.C. found that in 2000 a person with a disability in Wisconsin must spend 75% of his or her SSI monthly income to rent a modest one-bedroom apartment. Throughout Wisconsin, it is not uncommon for a HUD-approved rental voucher user with a disability to be put on a 1-2 year waiting list because there is insufficient affordable rental stock that is also "accessible." While changes need to occur on the federal level to provide for more Section 8 vouchers and increase the representation of persons with disabilities benefiting from the various federal housing programs, Wisconsin needs to ensure that it maximizes the opportunities available through these programs.

Deaf/Hard of Hearing (D/HOH): Persons who are D/HOH are subject to mental illness to the same degree as the rest of the population. Additionally, dealing with the hearing impairment may create behavioral or emotional challenges in and of itself. And yet there are few mental health treatment services designed for the D/HOH and a shortage of funds to purchase interpreter services to allow persons who are D/HOH to access traditional providers. Wisconsin needs to better assess the needs of this special population. At a minimum, service funds to support interpreters must be increased while specialized services are developed.

Part 3

Service Snapshots

SERVICE SNAPSHOT: COMMUNITY SUPPORT PROGRAMS

Overview: Community Support Programs (CSPs) are a cornerstone of the public mental health treatment system for adults and to a lesser degree for adolescents. These programs have been extremely successful in reducing inpatient hospitalization and increasing independence.

CSP Program Facts:

- 72 certified programs.
- In SFY02 the Wisconsin Medicaid program spent $18.6m. for CSP services and served 4,800 individuals.
- The corresponding state share that counties/tribes must provide as match is $13.5m.

CSPs were pioneered in Wisconsin. The first such program—the Program for Assertive Community Treatment (PACT)—was developed at the Mendota Mental Health Institute. It has now become a national model as an evidenced-based program for treatment of mental illness.

In the 2001-2003 biennial budget, the Legislature approved $1 million annualized to provide additional CSP services. The DFHS developed a procedure for counties/tribes to request funds to remove individuals from the waiting list. The DHFS received requests to fund 432 individuals at a total cost of $1.9 million but were able to fund only about 300. It is likely that this does not represent all Medicaid eligible individuals who could benefit from this service. Therefore, it is evident that this issue has not been adequately addressed.

Based on data from a 1999 monitoring report:

- CSP recipients had only 3.7 days of inpatient hospitalization per year.
- 28% were competitively employed, full or part time.
- 83% were living in housing of their choice, 65% were in some type of independent housing.
- Only 3.6% had had any criminal justice system involvement.

Wisconsin continues to work at improving the quality of this program. During 2002, the DHFS sponsored listening sessions for persons with mental illness receiving services through CSPs. These sessions were designed to identify how CSPs can do a better job of supporting the recovery process.

"Joy", (not her real name) was referred to a community support program (CSP) because her struggles with mental illness and alcohol and drug abuse had led to years of hospitalizations, homelessness, and legal problems. In just the six months since joining the CSP, Joy has started working four days a week, taking medications regularly, is maintaining her sobriety, and is obtaining treatment for other medical conditions that have interfered with her functioning.

SERVICE SNAPSHOT: INTEGRATED SERVICE PROGRAMS

Overview: Integrated Service Program (ISP), or "wraparound," is both a philosophy of care for youth with emotional disturbances and a program model. As the name suggests, the core feature of wraparound, is to wrap services around children and their families, keeping children in their homes to the degree possible.

Wraparound facts:

- 27 counties will receive $1.8m. MHBG in 2003.
- Milwaukee and Dane Counties operate managed care projects using wraparound philosophy. Six northern counties provide wraparound through a federal grant.
- Over 2500 children and family members were served in 2001.

Wisconsin has statutory language supporting the wraparound concept—46.56 Wis. Stats. defines the requirements for ISPs. A core feature is the interagency collaboration of the various systems impacting children and families: mental health, substance abuse, child welfare, juvenile justice and education. For wraparound programs to succeed, this collaboration must filter down to individual service teams and must include active participation of the families themselves.

- **ISP Outcomes: (based on data from the mental health block grant report on wraparound programs):**

✓ Significantly reduce emotional impairment.

✓ Lead to a steady improvement in living situations.

✓ Reduce juvenile justice system involvement.

✓ Improve school attendance rates.

Wisconsin has funded wraparound services since 1988. However, little program expansion had occurred for a number of years prior to 2002. In the 2001-2003 biennial budget, the Legislature earmarked additional MHBG funds to expand wraparound programs. This has resulted in new counties submitting proposals to provide this modality. The wraparound concept has also been expanded to serve a broader range of children served by multiple systems and to ensure that all systems contribute to the programs.

Frances entered the ISP as a 13 y/o who was delusional, physically and verbally aggressive, and unable to function in an academic setting. She had had multiple hospitalizations. Following her enrollment in the ISP her hospitalizations decreased, she was able to transition back to her community high school and will graduate in 2003. Frances is in a secretarial training program with DVR, has received her driver's license and is currently employed.

SERVICE SNAPSHOT: CONDITIONAL RELEASE PROGRAM

Overview: The Conditional Release (CR) program provides community-based treatment services and supervision to individuals found not guilty by reason of mental illness of a criminal charge. Patients are either placed directly onto CR in the community by the court or have been granted a conditional release following an inpatient stay at one of the two Mental Health Institutes. By law, persons placed on CR are the responsibility of the Department of Health and Family Services and the CR program exists to carry out this statutory obligation.

CR Program Facts (FY 2002):

- Average daily population: 251
- Diagnostic profile: schizophrenia, other psychotic or mood disorders,
- Average annual cost per client:, $30,476 based on average daily population (ADP)
- Average GPR cost per client: $13,270 (ADP)
- Average Medicaid cost per client: $7,334 (ADP)
- Average client pay: $9,864 (ADP)

DHFS uses an intensive case management approach to managing care for persons in the CR program. Service provision is provided through contracts with four private providers covering the six different regions of the state. Regional providers prepare a detailed conditional release plan that is submitted to the court for approval before the individual is released to the community. Direct services are provided through subcontracts under the regional providers.

The role of the probation and parole agents is to provide supervision and to ensure that the client meets the conditions of his/her conditional release plan. Each region has a designated regional specialist and specific agents who work with the clients conditionally released to their region. The agent assigned to a particular client works in conjunction with the regional CR providers and serves as a member of the treatment team.

CR Outcomes (FY 2002)

- Only 1.8% committed a new crime.
- Only 8% were revoked (vs. 38% for similar individuals exiting corrections without this program).
- 49% achieved competitive employment.
- 67% were living independently.

Capturing alternative funding sources (to state GPR) is a contract expectation of the regional providers and is monitored carefully by the CR specialist staff. Clients eligible for federal monies are expected to apply and are assisted in filing applications and appeals should initial applications be denied.

Joe has paranoid schizophrenia and was found not guilty by reason of mental illness. Joe entered the CR program after 11 ½ years at Mendota. While his costs were high for the first 2 ½ years in the CR program, they have been under $1000/year for the past four years. Joe lives independently, is in full time competitive employment and is involved in his community.

SERVICE SNAPSHOT: RECOVERY AND CONSUMER OPERATED SERVICES.

The Governor's Blue Ribbon Commission on Mental Health endorsed a vision of a mental health system based on a recovery model. This meant that people with mental illness were understood to be able to identify and achieve goals despite the continued existence of a mental illness, just like individuals with other chronic illnesses can continue to work, have families and prosper despite the possible need for continued treatment.

Consumer Operated Services

- 15 programs are funded through the Grassroots Empowerment Project.
- 1278 consumers were provided with peer services in 2002.
- Sites made 128 presentations on mental health topics to 3985 persons and provided 2894 individuals with information or referral.
- Held annual Consumer Conference with 165 participants.

However, while the concept of recovery may seem familiar from other areas of health care, a number of changes are needed within the mental health system in order to promote recovery for persons with mental illness. The mental health system has too long viewed persons with mental illness as incompetent and requiring long-term maintenance. In fact a 1980s documentary on community-based mental health care was titled "Clients for Life."

Recovery in Action (RIA)

- RIA is a consortium of groups and individuals led by SOAR Case Management Services.
- Developed "Core Competencies in a Recovery-Oriented Mental Health System"—a training curriculum.
- Trained services providers on assessing risk and maximizing choice.
- Completed needs assessment that measures current consumer and family involvement at the local level.

Creating a system that promotes recovery requires both attitude changes—among both providers and consumers—as well as practice changes. The budding research in this area suggests that positive outcomes for persons with mental illness are associated with real improvements in the degree to which consumers are active participants in their care planning. Availability of a variety of choices is critical to match consumers with the services they feel they need—a process which is associated with positive outcomes.

Programs operated by mental health consumers are another tool that promotes recovery. Consumers both develop their own skills and competence through their involvement in such programs as well as modeling that competence to other consumers. While research into such programs is at an early stage, there is evidence that such programs are no less effective than traditional services (or as part of a service system) and may cost less.

SERVICE SNAPSHOT: PREVENTION/EARLY INTERVENTION

The Governor's Blue Ribbon Commission on Mental Health recommended a renewed emphasis on prevention and early intervention in mental health, targeting disorders known to be amenable to such efforts:

- Depression in all age groups.
- Post-traumatic stress disorder in all age groups.
- Conduct disorder in youth.

Through a grant with the Mental Health Association in Milwaukee County a statewide initiative has begun to promote prevention and early intervention in mental health. While working with the public mental health system, the initiative also stresses collaboration with other systems, such as public health and aging, and addressing systemic barriers to prevention/early intervention.

Prevention/Early Intervention

- Awarded eleven mini-grants to demonstrate efficacy of P/EI.
- Provided training to 450 public health nurses on mental health issues of parents and children.
- Provided training to 900 student services staff on youth depression and suicide.
- Outreach and resource development to Hispanic, Hmong and Native American communities.
- Developed Web sites and did 40 TV spots on mental health issues.

SERVICE SNAPSHOT: FAMILY SUPPORT

Providing information, education and support to families of persons with mental illness has been shown to be effective in achieving better outcomes. Because many people are ill-informed about mental illness and because the systems that interface with persons with mental illness (including the criminal justice system) can be overwhelming and confusing for families to deal with, such family support activities are critical for ensuring that families can help their family members with mental illness receive the most appropriate care and avoid negative consequences associated with the illness.

Wisconsin Family Ties

- Employs 13 advocates who served 893 families with children with emotional disorders.
- Produces a quarterly newsletter with a circulation of 7000.
- Sponsored 10 parent participation workshops and assisted in other trainings.

NAMI Wisconsin

- Sponsors a variety of family, consumer and provider educational events.
- Publishes a bimonthly newsletter and maintains a resource library.
- Distributed thousands of copies of a Consumer Resource Guide and translated it into Braille.
- Distributed 50,000 referral cards.

WISCONSIN COUNCIL ON MENTAL HEALTH
Membership List
January 2003

NAME	MEMBERSHIP TYPE
Les Higgenbottom, **Chair** Milwaukee WI	Independent Care (I Care) Mental Health Provider
Barry Blackwell Shorewood WI	Advocate
Nic Dibble Interim Representative	State Agency Dept. of Public Instruction
Cleo Eliason, Interim Representative Alternate, Steve Stowell	State Agency Dept. of Workforce Development
Ginger Fobart Kenosha WI	Family Member Parent of Child with SED
Helen Geyso Kenosha WI	Family Member Parent of Adult with MI
Bob Harms Ashland WI	Consumer
Dr. Kevin Kallas	State Agency Department of Corrections
Wendy Kilbey Westfield WI	Family member Parent of Child with SED
Barbara J. Mamerow Green Bay WI	Advocate Older adults with MI
Sinikka McCabe	State Agency DHFS/DSL
John A. Quaal Pewaukee WI	Family Member Parent of Adult with MI
Martha Rasmus Milwaukee WI	Advocate
Ruth Roschke Madison WI	Consumer
VACANT Alternate: Julie Hovden	State Agency Division of Housing
Mark Strosahl Rhinelander WI	County representative
Lawrence A. Schomer Neenah WI	State Agency and Consumer Winnebago Mental Health Institute