SECTION III - PART B:

WISCONSIN'S

CHILD MENTAL HEALTH PLAN

FEDERAL FISCAL YEARS 2006-2007

Criterion 1: Comprehensive Community-Based System of Care

Wisconsin has been a national leader in the development of services for persons with mental illness. In the children's mental health field, WrapAround Milwaukee has pioneered the use of managed care techniques to serve the complex needs of youth with a serious emotional disorder who may also be involved in the juvenile justice, child welfare, or substance abuse systems. Wisconsin has also been facilitating the use of the system of care principles recommended by the Center for Mental Health Services through its integrated services for children's programming initiatives.

Recent Wisconsin Trends and Activities

Governor's KidsFirst Initiative

In 2004, Governor Jim Doyle proposed a four-part initiative to improve the physical and mental health of children in Wisconsin. The four parts of the KidsFirst Initiative are:

- **Ready for Success** focuses on improving the quality of and expanding access to early childhood programs from child care to four-year-old kindergarten;
- **Safe Kids** involves strategies to prevent child abuse and neglect through a coordinated system of home visits, improved foster care and adoption services, and investments to reduce family violence. Safe Kids also calls for a stronger, more accountable child welfare workforce, with the training and support necessary to protect Wisconsin's children. The plan also calls for a pilot project to ensure that children entering foster care have a physical and mental health exam and receive the medical care they need;
- **Strong Families** calls for a universal system of home visits, strengthened enforcement of child support, and an effort to break the cycle of incarceration; and
- **Healthy Kids** will help ensure that our children are healthy by providing health care coverage to all of Wisconsin's children, increasing immunization rates, ensuring that our kids have access to a healthy school breakfast, and teaching our kids fitness and nutrition skills they can use to lead active lifestyles.

Comprehensive Community Services Benefit

The 2003-05 state budget included authorization to expand the scope of psychosocial rehabilitation services that may be offered in Wisconsin under the Medical Assistance (MA) program. These new services are known as Comprehensive Community Services (CCS). The Divisions of Disability and Elder Service (DDES) and Health Care Financing worked together with an advisory workgroup to develop an emergency rule for CCS that became effective July 1, 2004.

CCS services complement those provided by existing Community Support Programs (CSP) by making a fuller array of mental health services available statewide to a large group of individuals in need. The new rule allows for the creation of a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to both children and adults, including elders, whose psychosocial needs require more than outpatient therapy, but less than the level of intense services provided by existing CSPs. Certified CCS programs may be funded by MA with county match.

CST Initiative Expansion

The expansion of children's mental health services has been a long-standing goal of the WCMH, parents, providers, advocates, and the Department. Through increased funding from the Mental Health Block Grant, the CST initiative began in December 2002 with collaboration between multiple systems: mental health, child welfare, substance abuse, juvenile justice, and public instruction. Initiative funding is made available through a blend of Mental Health Block Grant, Substance Abuse Block Grant, state general purpose revenue, and child welfare dollars. This funding is being used to bring about a change in the way that supports and services are delivered to the expanded target group of families who require substance abuse, mental health, and/or child welfare services. In addition to blended funding, the initiative will reduce out-of-home placements, treat the family as a unit, develop strong cross-system partnerships, and support family participation in the decision-making process. Ten sites were selected. Each site is required to provide a substantial amount of matching funds and a clear plan for sustainability to ensure continuation after state funding ends. The goal is to provide funding for three to five years.

The roles of the parent, family, and consumer in CST are to be active members on state and local committees developed to establish policies and procedures, monitor progress, and to be active members on individual family teams. Support is provided to initiatives ensuring that barriers encountered by parents, families, and consumers will be overcome. These barriers include timing of meetings, childcare, transportation, and training, and will be resolved to ensure meaningful and successful involvement.

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

Child Welfare Program Enhancement Plan

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

Wisconsin's Continuum of Care

Wisconsin's comprehensive recovery-based mental health system for children provides a continuum of care which begins with prevention and places its emphasis on services based in the community. The continuum continues with more intensive services, including 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.

Prevention and Early Intervention

Prevention and early intervention efforts are an important part of Wisconsin's continuum of care. These efforts are in line with Goal 4 of the President's New Freedom Commission (NFC), which sees early mental health screening, assessment, and referral as becoming common practice.

The Mental Health Association (MHA) in Milwaukee County is the lead contracted agency for prevention and early intervention activities. MHA has developed a statewide strategic plan, and awards mini-grants each year to local prevention/early intervention projects and participated in a variety of cross-system efforts in aid of the strategic plan. MHA provides information on mental health and suicide prevention through a toll-free information line, a website, a resource center, and a variety of culturally relevant brochures and posters. MHA also provides direct assistance and support to consumers and families and public policy advocacy.

DHFS and the Department of Public Instruction (DPI) awarded six grants to promote youth suicide prevention efforts in schools around the state. Funding of $5,000 for each of the six grants came from the DHFS, DPI, and Joy Global Foundation, a private Milwaukee-area foundation. The six projects will focus on prevention and early intervention with youth populations at risk of mental illness. Implementation of the projects will provide prevention activities aimed to increase knowledge of mental disorders, or preventive initiatives aimed at target populations at risk of depression, conduct disorder, or posttraumatic stress disorder with an ultimate goal of earlier identification and referral of youth at risk of suicide.

Infant and Early Childhood Mental Health

The vision of the Wisconsin Initiative for Infant Mental Health (WIIMH) is to foster healthy development for every infant and child up to five years of age in Wisconsin by having his or her unique social, emotional, physical, and developmental needs met within the context of family, community, and culture. The mission involves three related but separate activities: disseminating information regarding the social and emotional development of infants and young children; promoting collaboration among providers, families, and others to build a seamless, full-spectrum service delivery system; and influencing public policy at all levels to support young children and their families.

The WIIMH organization officially started in October 2001. Its most significant project since then has been the completion of a Wisconsin Infant and Early Childhood Mental Health Plan, adopted by Governor Jim Doyle as a component of his KidsFirst Initiative. The plan guides the establishment of a mental health system for children under the age of five and their families, and will encompass mental health promotion, prevention, early intervention, and treatment. Over sixty volunteers serve on four sub-committees developing recommendations for the plan. Our hope is that through comprehensive and dedicated efforts, the initiative will be an inclusive and collaborative effort among all people in Wisconsin with an interest in mental health during the early years of life.

Outpatient Services

Outpatient mental health services are provided to many children through their county of residence's mental health services. Some counties employ staff for this purpose and others contract with outside agencies. Services are typically provided in the child's home or a therapist's office and may include, but are not limited to: assessment/diagnosis; treatment and, in some circumstances, medication planning, monitoring, and review; individual, group, or family counseling/psychotherapy; case management; wraparound coordination; and crisis services. In addition, schools provide services via a child's Individual Education Plan (IEP) if the child requires special education services.

There are services that may involve a child's short term, temporary stay in a setting outside their home. Respite services can be provided either in the child's home, a respite provider's home, or a facility that offers brief housing and supervision to give the caregiver temporary relief from the stress of continuous support. For some children, respite is included in their plan of care when the need is clearly established. For example, a child may spend a day every other weekend with a respite provider in the provider's home to improve their parents' ability to cope with the demands the child places on the family, or to provide the child a "break" from the home routine. Crisis services too can be in the child's home to stabilize a volatile situation or may involve a child staying in another setting for a short time, usually a few days in a "crisis home" or facility. In the case of both respite and crisis, the facility used often has another primary purpose but has a few beds available to a county or agency.

Wisconsin's Collaborative Systems of Care

Wisconsin's Collaborative Systems of Care go by many names: CST, Wraparound, ISP, and Children Come First are all approaches to respond to individuals and families with multiple, often serious needs in the least-restrictive setting possible. They are not specific programs or services, rather, a process based on family and community values that is unconditional in its commitment to creatively address needs. Creative services are developed by a client-centered team that support normalized, community-based options. Each team develops an individualized plan, which incorporates strengths of the participant and team to address needs. Participants are equal partners and have ultimate ownership of the plan.

Activities to Reduce Hospitalizations

The effort to reduce the rate of hospitalization for all residents, especially for children who have SED, continues. Even though the rate of inpatient utilization has declined, there has been an increase in service costs at both state-operated institutions. Analysis of available data suggests that ISPs have been effective in reducing children's hospital utilization when compared to counties and tribes without ISPs. Data from counties in the CST Initiative will also be analyzed for reductions in the use of inpatient and other institutional placements.

Wisconsin has reduced hospital use through hospital diversion funding (see efforts described below), crisis stabilization through increased emergency crisis services, telemedicine, and expanded community-based wraparound services. The true challenge lies in ensuring that ongoing hospital reduction is not offset by an increased use of other institutional placements, such as juvenile justice or adult corrections placements.

The DDES is responsible for managing the state's two mental health institutes: Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute in Winnebago. These facilities provide specialized, acute treatment to children and adolescents, adults, older adults, and forensic mental health consumers with the long-term goal of reintegration into the community. The institutions provide training and consultation as requested to community-based programs. The number of staffed beds for inpatient care for children at state institutions has decreased from 112 in 1993 to 84 in 2004, a decrease of 25 percent. An additional 15 beds for specialized AODA/MI treatment were added in 2004. There has also been a reduction in beds in county and privately operated facilities as units have closed due to decreased demand and for economic reasons.

Hospital Diversion Funding for Children with SED

Hospital diversion funding goes to selected counties and tribes to help reduce MA inpatient hospital psychiatric spending. Desired outcomes are to improve and expand community-based alternatives to institutional care. Hospital diversion funds are authorized in Wisconsin Statute 46.485. During 2004-2005 expanded crisis stabilization programs were funded through hospital diversion funding primarily for children/youth in Winnebago County and at least one other county to reduce use of inpatient services.

Additional funds may be made available for counties to begin providing services using a wraparound model to provide services in the community as an alternative to inpatient placements.

Additional state GPR funding in the amount of $500,000 was appropriated in the 2003-05 biennial budget for enhancing hospital diversion activities. Six multi-county grants of $100,000 that take a regional approach to increasing crisis stabilization services were offered in fiscal year 2005. They are currently in their second year of funding.

Program of Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model has multi-disciplinary mental health staff organized as an accountable, mobile team, who function interchangeably to provide treatment, rehabilitation, crisis, and supportive services. Mendota Mental Health Institute operates the PACT to provide comprehensive care. For the last several years PACT has engaged in a research project limiting new admissions to adolescents in an effort to evaluate the impact of early intervention. Preliminary findings indicate positive outcomes in the application of the model to youth and a study of cost effectiveness is forthcoming.

Case Management

Case management services are provided to children served by the child welfare system. In general terms, this means a case manager coordinates, provides, or advocates for intensive community services to meet a child's physical, psychological and developmental needs. Case managers can have an established relationship with the child and the family and work with them to navigate across multiple agencies.

Targeted Case Management

Medicaid targeted or intensive case managers generally have smaller caseloads than case managers, usually an average of 8-12 families. After eligibility is determined, case managers make initial contact with the child and family to determine the family's strengths. Under Medicaid, Wisconsin provides targeted case management, inpatient hospitalization, and outpatient clinic and other services for individuals under the age of 21. It also provides medically mandated necessary services such as medication checks, assessment, and diagnosis if a provider can be found that accepts Medicaid.

The definition of the targeted case management includes families whose children are at risk of serious physical, mental, or emotional dysfunction. This concept, referred to as Family Care management, expands coverage to families that include one or more children who have special health care needs, are at risk of maltreatment, or are involved in the juvenile justice system, as well as families where the mother requires prenatal care coordination services.

Medicaid has paid for targeted case management services since 1987. While counties and tribes are the only agencies that may receive reimbursement for these case management activities, they may sub-contract with other entities that provide direct services to children and their families.

Mental Health Managed Care Programs for Children

Wisconsin has two Medicaid managed care programs for mental health services for children with SED and who are at risk for out-of-home placement: Children Come First (Dane County) and Wraparound Milwaukee. The programs are managed by the Division of Health Care Financing (DHCF).

Transitional Services for Adolescents to Adult Services

The Mental Health Transition Advisory Council (MHTAC) has been in existence for over four years, initially collecting information and research. A statewide plan and action steps were then developed to

improve the transition of youth with SED to the adult mental health services they may need and the highest level of independent living they are capable of attaining. MHTAC members represent a collaboration of several Departments, Divisions, advocacy agencies, both adolescent and adult programs in several counties, and parents. Steps have been taken in several areas for improving the transition process in Wisconsin, most recently four regional mental health/transition training days at the end of 2004. More are planned for 2005 for the northernmost areas of the state. Hundreds of two products of the MHTAC, "Transition Resources for Adolescents with Mental and/or Emotional Disorders and Their Families" and "Do It Yourself Case Management," have been distributed statewide to providers, program administrators, family members, teachers, and other key stakeholders and are also available electronically.

MHTAC members have facilitated informational transition evening sessions for parents and youths, have collaborated with Independent Living Coordinators serving youth in foster care, provided materials and presentations at conferences, and have offered scholarships to UW-Whitewater's transition camp. Future goals include development of a DHFS web site in addition to www.wicollaborative.org, sponsorship of training adult CSP staff to prepare for adolescent clients, continued advocacy for youth in transition in emerging statewide initiatives, outreach to secondary education programs and juvenile corrections to better accommodate youth with SED, and increased awareness of this population's challenges via existing conferences, informational events, etc. Both adolescent CSPs and post-secondary education options for teens with SED will be featured topics at the Children Come First Conference in 2005. Outreach continues with Cooperative Educational Service Agencies (CESAs) collaborating with the Division of Vocation Rehabilitation (DVR) in the Department of Workforce Development to work with transitioning teens who receive special education services

The CCS Rule is a welcome asset to youth in transition since it does not compartmentalize services by age. Information about that Rule, new benefits and benefits counseling, and university and technical colleges support services will be featured in information and training in 2005 and updated as needed for 2006.

Day Treatment

Day treatment is a higher level of treatment than other community-based services. Based on the child's needs, day treatment maintains him/her in the home and in the community by providing part or full day supervision and treatment, usually utilizing group therapy. Some day treatment sites offer education credits and tutoring. An example of use of day treatment would be a teen attending a program offered by a hospital or treatment center where he is supervised, engages in group therapy, and does school work part of the day.

Residential Services

In cases where day treatment services do not provide sufficient supervision and treatment, the usual next step is group home or residential services. As the name implies, children live at the treatment center, often attending school on grounds, and participate in group and other treatment options addressing chronic behavior or emotional problems. Residential treatment is usually considered long term, of several months' duration.

Inpatient services

Wisconsin has several local hospitals and two mental health institutes that serve children with mental health needs that require hospitalization. Over the past 15 years Wisconsin has emphasized the development of community-based mental health services for children and adults. As a result there has been a dramatic shift from institutional treatment to providing local services and supports to children with

SED and their families. Also, as a consequence Wisconsin has seen the loss of local inpatient psychiatric bed capacity for children. Several hospitals have closed admissions to children and adolescents and many have cut bed capacity. Even though the overall admissions to all psychiatric beds for children and adolescents have been reduced, especially the length of stays, the two mental health institutes have been operating at capacity or over capacity. Mental health institute beds for children and adolescents have decreased over the past five years (from 125 beds in 2000 to 84 beds in 2005) while the number of admissions to those beds has increased (832 admissions in FY 00 compared to 920 in FY 05).

Wisconsin is faced with several challenges in terms of reduced bed capacity and increased demand. The care of children at the state institutes is covered by Medical Assistance, with no cost to the county; increase in AODA including methamphetamine admissions; increased need for hospital services for elders; and admissions that could be diverted if there were local community services available. In response to these demands Wisconsin continues to develop local crisis stabilization hospital diversion alternatives for all age groups. Over the next 2-3 years there will be at least another 8-12 counties certified to provide higher level crisis intervention services that are supported by Medical Assistance and private insurance. The new CCS benefit will provide much needed support for individuals who fall between traditional out-patient clinic services and more intense CSP services. These programs and others will help to strengthen the community's ability to respond to individuals who may have otherwise required hospitalization, and or to shorten the length of inpatient stay.

State Mental Health Institutes

Both Mendota and Winnebago Mental Health Institutes provide excellent assessment and treatment services and programs for children and adolescents. The Institutes back-up the local mental health system when a child requires a comprehensive mental health assessment that can not be provided for in the community, safety due to risk of suicide and/or other dangerous behaviors to self or others and/or the need for a very structured longer-term treatment environment.

The two state mental health institutes offer on-staff physicians, nurses, occupational therapists, social workers, aids, etc. like a community inpatient unit, but do so in a more secure, highly supervised and monitored locked setting. They are used for youth who are experiencing acute psychiatric symptoms and need a safe environment for stabilization, medication evaluation, and/or present a danger to themselves or others. Children and youth can be admitted voluntarily or on court order.

Other Services to Promote Recovery

Consumer Support and Advocacy

A high priority for current initiatives is to increase parent and family involvement in the treatment of their children. Mental Health Block grant funds are allocated to Wisconsin Family Ties (WFT), the Wisconsin Council on Children and Families (WCCF), and NAMI Wisconsin to accomplish this, and continued funding is critical to a redesigned system. Currently, some counties fund family advocate positions. Additional family advocacy, parent education, and support are provided by Milwaukee's Families United, Inc, Wisconsin Family Assistance Center for Education, Training, and Support (FACETS), and the Mental Health Association in Milwaukee County.

WFT is the primary statewide, family-run organization in Wisconsin working with children with SED and their families. Their mission is to bring hope to families that include children and adolescents who have mental, emotional, and behavioral disorders. They accomplish this by providing a variety of parent-to-parent support, education, and advocacy services, as well as by providing information on family rights, available public/private programs, and treatment options. WFT produces a quarterly newsletter, offers a toll-free help line for information, provides resource materials, assists in the formation and maintenance

of community-based support groups, and sponsors educational opportunities through scholarships to family members.

Families United of Milwaukee, Inc., is another family advocacy and support group that serves the Milwaukee Metro area in providing essential peer-to-peer support to families who have children with SED and are enrolled in Wraparound Milwaukee. The group also serves families throughout Milwaukee County, even if they are not enrolled in Milwaukee Wraparound.

Substance Abuse Services

Wisconsin provides a range of AODA-certified services, including prevention, emergency outpatient, four levels of detoxification, five levels of rehabilitation, and one level of narcotic treatment services. There are 111 service agencies that provide a specialty service in working with adolescents/ youth AODA treatment. Treatment modalities range from topical group work, one-on-one counseling, family counseling, and educational opportunities to experiential interventions such as a ropes team course.

Youth enter the AODA treatment service system through a variety of sources. The two predominant referral bases are local community schools and local law enforcement. DPI completes an annual survey of Wisconsin students to determine current trends in drug use and intervention strategies. In 2002, survey results showed Wisconsin students had demonstrated successful outcomes in a peer development model. All local criminal justice systems develop their own community-specific juvenile court intervention services.

The Bureau of Mental Health and Substance Abuse Services (BMHSAS) received a grant from the federal Center for Substance Abuse Treatment that targets screening, early intervention, assessment, and linkages for adolescents referred to the juvenile justice system. There are nine contracts operating within eleven county human services delivery systems in Wisconsin, located in counties with wraparound services. These counties are Milwaukee, Kenosha, Fond du Lac, Outagamie, Portage, Dunn, Eau Claire, Dane, and Forest/Oneida/Vilas. All of the sites utilize the Problem Oriented Screening Instrument for Teenagers (POSIT) screening tool and complete appropriate referrals for further assessment and treatment services based on the initial screen, supporting collateral information, and the availability of services. The tool flags assessment areas for mental health issues, AODA issues, family dysfunction, juvenile delinquency, and education issues or difficulties. It is anticipated that the Bureau will create additional cross training opportunities and enhanced integrated provision of mental health and substance abuse services to better serve youth that engage in substance abuse and dependency and also have mental health issues.

Services Provided under IDEA

Students with an emotional or behavioral disability (EBD) are eligible for services under Individuals with Disabilities Education Act (IDEA). In the 2004-2005 school year, 16,449 students (ages 3-21) were identified as having a primary disability of EBD. The data on the prevalence of EBD in all of Wisconsin's public and private school districts for the 2004-2005 school year is not yet available.

In December 2004, President Bush signed the Individuals with Disabilities Education Improvement Act of 2004. Most of the provisions of the new law took effect in July 2005. The new law aligns the previous IDEA with the provisions of the No Child Left Behind Act.

Employment Services

A primary function of each adolescent's IEP is to provide assistance, supports, and rehabilitation services to meet their educational and vocational goals. Ideally these services should be implemented through

integrated and wraparound processes and the IEP should reflect and support these. Some training on how to provide needed supportive education services is available to schools through the DPI and their contract with the Cooperative Education Service Agencies (CESAs). Other training opportunities include the annual Children Come First, Crisis, Wisconsin Statewide Transition Initiative, and Transition and Rehabilitation Conferences. Experienced practitioners from within and outside of Wisconsin are trainers at these events, which are strongly focused on the needs of young adults.

DVR has over 200 counselors who are assigned as liaisons to over 400 school districts in Wisconsin. DVR and DPI have established a new interagency agreement for the delivery of vocational services to youth in transition from high school to adult services and employment. DVR and DPI, in cooperation with CESAs, are conducting training on the agreement and new IDEA regulatory provisions around the state.

Barriers to better employment and educational experiences include the lack of advanced planning, insufficient supportive services targeted for youth/adolescents, lack of employment opportunities both during and post high school, funding, accommodation issues, and stigma. The complexities of work eligibility, fragmentation of services and information around work, earned income, and access to critical health care supports have traditionally made employment outcomes poor. The most common source of supported employment comes from DVR funding. However, this funding is contingent upon the degree of functional impairment of the individual, and only those with severe impairment are currently being served by DVR.

Families and consumers have requested increased access to benefit specialist services and the Benefits Planning, Assistance, and Outreach Program, a 5 year demonstration project funded by the Social Security Administration, has accomplished this. They are available to every county and for people with disabilities ages 16 – 64. There are also many fee-for-service benefit counseling services, which can be paid for privately or via community and vocational agency funding, such as DVR funding. These specialists also address housing, food stamps, and health insurance in addition to Supplemental Security Income (SSI) and Social Security Disability Insurance. The Medicaid Purchase Plan and Health and Employment Counseling (HEC) are relatively new programs that make employment more attractive to older teens because these programs provide for health care coverage to those people with disabilities who work, and in the case of HEC, those who are looking for employment.

Housing Services

In Wisconsin, advocates and others support the right of consumers with mental illness to have safe, affordable housing and choice in selecting housing in their community. Several communities have active, organized efforts leading toward outcomes to reduce concentrated housing in their neighborhoods. Most communities offer Section 8 housing vouchers for rental assistance to low-income families and individuals. However, there are not enough vouchers to meet the need in most communities.

Parents, families, and consumers have voiced their preference to have housing options with supportive services offered in a recovery-oriented system. The BMHSAS, the Wisconsin Council on Mental Health, the Division of Housing, and other system partners recognize that there is a need for continued work in all communities to offer safe, affordable and preferential housing options. Reducing stigma and discrimination from landlords towards families who have children with SED is important and must continue to be addressed.

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.

The Wisconsin Managed Care Context - Wisconsin has a strong track record in the design and management of Medicaid managed care programs, innovative demonstrations, and long-term care waiver programs. Health and long-term care represent over 80 percent of the Department's Medicaid budget. Persons on SSI automatically qualify for Medicaid services. Relevant examples of Wisconsin programs include those summarized below.

The HMO Program – The HMO Program was initiated in 1984 to manage Medicaid benefits to recipients of Aid to Families with Dependent Children statewide. The HMO Program contracts with 14 HMOs serving 66 of Wisconsin's 72 counties. Requests for proposals for a managed care program to serve Milwaukee's children in foster care have been solicited.

BadgerCare – BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185 percent of the federal poverty level through a Medical expansion under Titles XIX and XXI. The program goal is to fill the gap between Medicaid and private insurance without supplanting private insurance. BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid, and recipients' health care is administered through the same delivery system. No asset test is required.

According to the Statistical Abstract of the United States, in 2002 4.6 percent of children in Wisconsin under the age of 18 did not have health insurance, which was the lowest rate in the nation. The U.S. rate in 2001 was 11.6 percent. Texas had the highest rate of uninsured children (22.4 percent).

Katie Beckett Program – The Katie Beckett Program allows certain children with long term disabilities or complex medical needs, living at home with their families, to obtain a Wisconsin Medicaid card. As of March of 2005, there were 514 children enrolled in the Katie Beckett program with a primary diagnosis of SED.

Children who are not eligible for other Medicaid programs because their parents' income or assets are too high may be eligible for Medicaid through the Katie Beckett Program, if the child:

1. is under 19 years of age and determined to be disabled by standards in the Social Security Act,
2. requires a level of care at home that is typically provided in a hospital or nursing facility,
3. can be provided safe and appropriate care in the family home,
4. as an individual, does not have income or assets in his or her name in excess of the current standards for a child living in an institution, and
5. does not incur a cost at home to the Medicaid Program that exceeds the cost Medicaid would pay if the child were in an institution.

If the Katie Beckett Program application is approved, the child will receive a Medicaid card which can be used to pay for services and equipment allowed under the Wisconsin Medicaid Program.

Health Check Program -- Health Check is a federally-mandated Medicaid program known nationally as Early and Periodic Screening, Diagnosis, and Treatment. Health Check consists of a comprehensive health screening of Medicaid recipients under the age of 21. The screening includes, but is not limited to the following:

- a review of the recipient's health history,
- an assessment of growth and development,

- identification of potential physical or developmental problems,
- preventive health education, and
- referral assistance to providers.

The Health Check screen will determine if a child is eligible for services that are not otherwise in Wisconsin's MA State Plan but are allowable under MA federal regulation. Services include case management, outpatient therapy, inpatient services, day treatment, and intensive in-home services. Other physical, mental, or dental health problems discovered in the Health Check examination are also referred for further diagnosis and treatment. The use of the Health Check system to screen for Medicaid-eligible children who have SED appears to be underutilized, and this underutilization creates an opportunity for increased public and provider awareness and education.

Dental Services -- Access to dental services continues to be a problem for Medicaid recipients in the state. Dental care services were given increased focus during contract negotiations with certain HMOs which cover dental services in order to increase access to those services. As of March 2003, dentists do not need to receive prior authorization for some dental procedures (i.e., root canals) for recipients under the age of 21. For children/youth who have SED and may be on psychotropic medications, a lack of dental care could have serious side effects. Poor dental care affects children's nutrition, growth, development, and well-being.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 1

Goal 1:	**To expand wraparound services to all counties.**
Objective:	To annually increase by two the number of counties with initiatives using the wraparound model in FFY 2006-2007.
Population:	Children with SED and their families.
Criterion:	Comprehensive Community-Based System of Care.
Brief Name:	Expand children's wraparound programs.
Indicator:	Percentage of counties with wraparound initiatives.
Measure:	*Numerator:* Number of counties with wraparound initiatives in FFY 2006-2007. *Denominator:* Number of counties in Wisconsin.
Sources of Information:	Department funding information for wraparound programs.
Special Issues And Strategy:	The ultimate goal for Wisconsin is to expand integrated service programs using a wraparound approach in all counties statewide. Thus, to best reflect progress towards that goal, the indicator is stated as the percentage of all counties because it illustrates state coverage more effectively than the number of all counties. Not all county programs serving children are funded through the Mental Health Block Grant. The two largest counties sustain their children's wraparound initiatives solely through Medicaid and county funds (see the performance indicator table for details). All of these county programs are included in this performance indicator.
Significance:	The expansion of wraparound service programming for children is one of the top priorities of Wisconsin's Mental Health Council and the BMHSAS. With its emphasis on the family being a part of all treatment decisions, wraparound programs are in accordance with NFC Goal 2.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: FFY 2006-2007

Population: Children with SED and their Families

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator: Expand children's wraparound programs	**FFY 2003 Actual**	**FFY 2004 Actual**	**FFY 2005 Actual**	**FFY 2006 Target**	**FFY 2007 Target**
Value:	47%	56%	56%	58%	61%
Numerator:	34	40	40	42	44
Denominator:	72	72	72	72	72

Action Plan

In FFY 2006, Wisconsin will add two additional CSTs. We will use funding from multiple sources to fund the new CSTs. In addition, we will explore the possibility of providing support in the form of technical assistance and training to additional counties which will allow them to start a CST program in the absence of additional funding from the state. One County (Grant County) that received this technical assistance but is not receiving funding from the state is already operating a CST.

In FFY 2007, Wisconsin will add two additional CSTs. The funding agreements for the first CST programs stipulated that the counties would receive funding for a period of three to five years. As the funding period for the original CSTs ends, we will use direct the funds to new counties for implementation of CST programs.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 1

Goal 2:	**To facilitate the use of evidence-based practices for children. (National Outcome Measure)**
Objective:	To facilitate the use of evidence-based practices for children by funding their implementation and disseminating training resources in FFY 2006-2007.
Population:	Children with SED and their families.
Criterion:	Comprehensive Community-Based System of Care.
Brief Name:	Evidence-based Practices Used.
Indicator:	Number of evidence-based practices used for children in the state in FFY 2006 and 2007.
Measure:	Number of evidence-based practices used for children in the state in FFY 2006 and 2007.
Sources of Information:	To be determined.
Special Issues and Strategy:	The first challenge for Wisconsin is collecting reliable statewide data on the use of evidence-based practices. We will use funding from the Data Infrastructure Grant (DIG) to develop a data collection system.
Significance:	The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **FFY 2006-2007**

Population: **Children with SED and their Families**

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

Performance Indicator: Number of Evidence-based Practices Used	**FFY 2003 Actual**	**FFY 2004 Actual**	**FFY 2005 Projected**	**FFY 2006 Target**	**FFY 2007 Target**
Value:	0	0	0	0	1
Numerator:					
Denominator:					

Action Plan

Data on the use of evidence-based practices is required by CMHS to be in the State Mental Health Plan for the first time in FFY 2005. Evidence-based practice data are also required by CMHS to be reported in Developmental Data Tables 16-17 for the Implementation Report. Wisconsin submitted an application for a new DIG for FFY 2005 in June 2004 with plans to collect data on evidence-based practices. Reports on the use of evidence-based practices and medications should come from providers. One of the data collection methods being considered by Wisconsin is a survey administered to key provider staff in each county. These data on the use of evidence-based treatments could be used not only to complete Developmental Data Tables 16-17, but also to create an evidence-based practice resource directory for the state.

In FFY 2006 Wisconsin will undertake an assessment of the options for implementing one or more evidence-based practice for children's services, including significant background research on the needs of the state and the elements of the evidence-based practices. Once the assessment of the use of evidence-based practices is complete for the state, decisions can be made about which evidence-based practices can be used as resources throughout the state. The state will help facilitate the dissemination of training resources across counties for the implementation of evidence-based practices for children.

The state will research and implement a new evidence-based practice in FFY 2007. The BMHSAS will fund an expert trainer to come to Wisconsin and train BMSHSAS staff or contracted staff and a sample of local providers. Trained BMHSAS staff will become the ongoing technical assistance providers based on their training. The first local providers to be trained will be part of a program to convert them to trainers to help spread the evidence-based practice to other counties.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

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 2006-2007.
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 2006 and 2007.
Measure:	Number of children receiving evidence-based practices in the state in FFY 2006 and 2007.
Sources of Information:	To be determined.
Special Issues and Strategy:	The first challenge for Wisconsin is collecting reliable statewide data on the use of evidence-based practices. We will use funding from the DIG to develop a data collection system.
Significance:	The use of evidence-based practices is expected to increase the effectiveness of treatment and consumer satisfaction levels if implemented in a manner faithful to the model.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: FFY 2006-2007

Population: Children with SED and their Families

Criterion: Comprehensive Community-Based Mental Health Service Systems

Performance Indicator: Number of Children Receiving Evidence-based practices	**FFY 2003 Actual**	**FFY 2004 Actual**	**FFY 2005 Projected**	**FFY 2006 Target**	**FFY 2007 Target**
Value:	0	0	0	0	300
Numerator:					
Denominator:					

Action Plan

Data on the use of evidence-based practices is required by CMHS to be in the State Mental Health Plan for the first time in FFY 2005. Evidence-based practice data are also required by CMHS to be reported in Developmental Data Tables 16-17 for the Implementation Report. Wisconsin submitted an application for a new DIG for FFY 2005 in June 2004 with plans to collect data on evidence-based practices. Reports on the use of evidence-based practices and medications should come from providers. One of the data collection methods being considered by Wisconsin is a survey administered to key provider staff in each county. These data on the use of evidence-based treatments could be used not only to complete Developmental Data Tables 16-17, but also to create an evidence-based practice resource directory for the state.

In FFY 2006 Wisconsin will undertake an assessment of the options for implementing one or more evidence-based practice for children's services, including significant background research on the needs of the state and the elements of the evidence-based practices. Once the assessment of the use of evidence-based practices is complete for the state, decisions can be made about which evidence-based practices can be used as resources throughout the state. The state will help facilitate the dissemination of training resources across counties for the implementation of evidence-based practices for children.

The state will research and implement a new evidence-based practice in FFY 2007. The BMHSAS will fund an expert trainer to come to Wisconsin and train BMSHSAS staff or contracted staff and a sample of local providers. Trained BMHSAS staff will become the ongoing technical assistance providers based on their training. The first local providers to be trained will be part of a program to convert them to trainers to help spread the evidence-based practice to other counties.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 1

Goal 4:	**Increase consumer satisfaction with outcomes from their treatment. (National Outcome Measure)**
Objective:	To increase the number of parents/guardians annually who are satisfied with the outcomes of their child's treatment by 1 percent annually from FFY 2006-2007.
Population:	Children with SED.
Criterion:	Comprehensive Community-Based Mental Health Service Systems.
Brief Name:	Increase satisfaction with child treatment outcomes.
Indicator:	Percentage of parents or guardians of child consumers responding to the satisfaction survey with a "positive" response about the outcome of their treatment as measured by the Outcomes scale on the survey in FFY 2005.
Measure:	*Numerator:* The number of parents or guardians with a "positive" response about the outcome of their child's treatment as measured by the Outcomes scale in FFY 2006 and 2007. *Denominator:* The total number of parents or guardians responding to the youth survey in FFY 2006 and 2007.
Source of Information:	Mental Health Statistical Improvement Program's Youth Services Survey.
Special Issues And Strategy	A sample of parents/guardians of child mental health consumers is surveyed throughout the state. The sampling must be representative of the state and must be monitored. If the sample becomes unbalanced based on important demographic or geographic characteristics, a modified sampling approach will be used to correct the balance.
Significance:	Without understanding the consumer's and/or guardian's perspective on a child's service experience, a crucial piece of data is missing in understanding the effectiveness of mental health services.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **FFY 2006-2007**

Population: **Children with SED and their Families**

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

Performance Indicator: Increase satisfaction with child treatment outcomes.	**CY 2002 Actual**	**CY 2003 Actual**	**CY 2004 Actual**	**CY 2005 Projected**	**CY 2006 Target**
Value:	Not Applicable	48%	49%	50%	51%
Numerator:		178	256		
Denominator:		371	522		

Action Plan

Wisconsin collects consumer satisfaction data using the Mental Health Statistical Improvement Program's (MHSIP) adult and youth consumer satisfaction surveys. For assessing satisfaction with children's services, the Bureau uses the MHSIP Youth Services Survey that is administered to a parent or guardian of the youth. Funding from the DIG for FFY 2005-2007 has been budgeted to fund the administration of the satisfaction surveys.

In CY 2005, Wisconsin will analyze the data from the MHSIP to attempt to ascertain which services have the lowest scores for satisfaction, and the reasons for the low satisfaction with these services. In CY 2006, Wisconsin will begin planning for and implementation of strategies to increase satisfaction with these low-scoring services.

It is the intent of BMHSAS to move towards an outcome-based, consumer-focused system where quality improvement is built into the programs at the local level. To that end, we are developing mechanisms to collect outcome data and quality indicators and intend to change the way in which we evaluate the success of services and supports provided. We have developed a functional screen that local agencies can use to develop indicators from so that quality improvement efforts can be data driven. We have also developed a consumer outcomes measurement tool 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 three counties and will be offered to an expanding number of counties in the coming year to teach agencies how to do continuous quality improvement as an adjunct to regulatory compliance.

Criterion 2: Mental Health System Data Epidemiology

This section includes the definition used by the DHFS for children with SED and the methodology used to determine the number of children and families needing services. The following definition used by Wisconsin is nearly identical to the one used by the Center for Mental Health Services. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must be in evidence by (1), (2) (3) and (4).

(1) The disability must have persisted for 6 months and be expected to persist for a year or longer.

(2) A condition of SED as defined by:

A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic categories appropriate for children and adolescents[1].

(3) Functional symptoms and impairments consisting of either A. or B.

A. Symptoms - the individual must have one of the following:

1. Psychotic symptoms - serious mental illness, e.g., schizophrenia characterized by defective or lost contact with reality, often with hallucinations or delusions.

2. Danger to self, others, and property as a result of emotional disturbance. The individual is self destructive, e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons, or significant damage to property.

B. Functional impairment in two of the following capacities (compared with expected developmental level):

1. Functioning in self-care - Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

2. Functioning in community - Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment, and value systems, which results in potential involvement or involvement with the juvenile justice system.

3. Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

[1] Those DSM-IV categories are: substance related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somataform disorders, dissociative disorders, sexual and gender identity disorders, impulse-control disorders, adjustment disorders and personality disorders. Disorders usually first evident in infancy, childhood and adolescence including pervasive developmental disorders, attention deficit and disruptive behavior disorders, tic disorders, stereotypic movement disorder, feeding and eating disorders, separation anxiety disorder, selective mutism and reactive attachment disorder.

4. Functioning in the family - Impairment in family function is manifested by a pattern of significantly disruptive behavior. It is exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations, which may result in removal from the family or its equivalent.

5. Functioning at school/work

   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, e.g., consistently failing grades, repeated truancy, expulsion, property damage, or violence toward other,

   b) Identified as having as emotional/behavioral disability (EBD) under chapter PI 11, Wis. Admin. Code, and Section 115.76 Wis. Stats., and

   c) Impairment at work is the inability to be consistently employed at a self-sustaining level, e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, along with hostile behavior on the job.

(4) The individual is receiving services from two or more of the following service systems, i.e.; mental health, social services, child protective services, juvenile justice, or special education.

Prevalence Methodology

While there are different methods for estimating prevalence of mental illnesses, Wisconsin bases its estimation methodology on that of the CMHS. The BMHSAS estimated that there are 89,971 children with SED between the ages of 5-17 in 2002. The Census Bureau estimated Wisconsin's poverty rate for children 17 and under in 2002 was 10.9 percent. The national poverty rate for the same population was 16.7 percent. As Wisconsin is more than five percent below the national poverty level, the lower percent range is used for our prevalence estimates, as recommended by CMHS. Not all of these children will require specialized services nor do they need ISP level of service delivery. Some children can be served through outpatient services provided in the mental health and social services system.

Table 18
Wisconsin Prevalence Estimates of Children and Adolescents with SED

By County, 2002 Population* WI Poverty Rate = 11.0%** Placed in Group A, with the Lowest Percent in Poverty		Children with an SED and "Extreme Functional Impairment" Total Possible Range = 5% to 9% WI Range = 5% to 7% Level of Functioning Score = 50		Children with an SED and "Substantial Functional Impairment" Total Possible Range = 9% to 13% WI Range = 9% to 11% Level of Functioning Score = 60	
	# of Kids 5-17	Lower Limit @ 5%	Upper Limit @ 7%	Lower Limit @ 9%	Upper Limit @ 11%
Wisconsin	**999,680**	**49,984**	**69,978**	**89,971**	**109,965**
Adams	2,971	149	208	267	327
Ashland	3,061	153	214	275	337
Barron	8,289	414	580	746	912
Bayfield	2,711	136	190	244	298
Brown	43,208	2,160	3,025	3,889	4,753
Buffalo	2,463	123	172	222	271
Burnett	2,630	132	184	237	289
Calumet	8,673	434	607	781	954
Chippewa	10,644	532	745	958	1,171
Clark	7,139	357	500	643	785
Columbia	9,683	484	678	871	1,065
Crawford	3,196	160	224	288	352
Dane	71,028	3,551	4,972	6,393	7,813
Dodge	15,463	773	1,082	1,392	1,701
Door	4,617	231	323	416	508
Douglas	7,375	369	516	664	811
Dunn	6,726	336	471	605	740
Eau Claire	15,788	789	1,105	1,421	1,737
Florence	873	44	61	79	96
Fond du Lac	17,786	889	1,245	1,601	1,956
Forest	1,857	93	130	167	204
Grant	8,421	421	589	758	926
Green	6,547	327	458	589	720
Green Lake	3,242	162	227	292	357
Iowa	4,484	224	314	404	493
Iron	996	50	70	90	110
Jackson	3,359	168	235	302	369
Jefferson	13,564	678	949	1,221	1,492
Juneau	4,595	230	322	414	505
Kenosha	30,161	1,508	2,111	2,714	3,318
Kewaunee	3,864	193	270	348	425
La Crosse	18,233	912	1,276	1,641	2,006
Lafayette	3,187	159	223	287	351
Langlade	3,696	185	259	333	407
Lincoln	5,585	279	391	503	614
Manitowoc	15,397	770	1,078	1,386	1,694
Marathon	24,663	1,233	1,726	2,220	2,713
Marinette	7,481	374	524	673	823
Marquette	2,408	120	169	217	265
Menominee	1,250	63	88	113	138

By County, 2002 Population* WI Poverty Rate = 11.0%** Placed in Group A, with the Lowest Percent in Poverty		Children with an SED and "Extreme Functional Impairment" Total Possible Range = 5% to 9% WI Range = 5% to 7% Level of Functioning Score = 50		Children with an SED and "Substantial Functional Impairment" Total Possible Range = 9% to 13% WI Range = 9% to 11% Level of Functioning Score = 60	
	# of Kids 5-17	Lower Limit @ 5%	Upper Limit @ 7%	Lower Limit @ 9%	Upper Limit @ 11%
Wisconsin	**999,680**	**49,984**	**69,978**	**89,971**	**109,965**
Milwaukee	176,837	8,842	12,379	15,915	19,452
Monroe	8,394	420	588	755	923
Oconto	6,930	347	485	624	762
Oneida	6,099	305	427	549	671
Outagamie	32,782	1,639	2,295	2,950	3,606
Ozaukee	16,491	825	1,154	1,484	1,814
Pepin	1,373	69	96	124	151
Pierce	6,605	330	462	594	727
Polk	8,174	409	572	736	899
Portage	11,626	581	814	1,046	1,279
Price	2,767	138	194	249	304
Racine	37,042	1,852	2,593	3,334	4,075
Richland	3,326	166	233	299	366
Rock	29,614	1,481	2,073	2,665	3,258
Rusk	2,788	139	195	251	307
St. Croix	13,376	669	936	1,204	1,471
Sauk	10,545	527	738	949	1,160
Sawyer	2,889	144	202	260	318
Shawano	7,628	381	534	687	839
Sheboygan	20,900	1,045	1,463	1,881	2,299
Taylor	3,850	193	270	347	424
Trempealeau	5,027	251	352	452	553
Vernon	5,671	284	397	510	624
Vilas	3,356	168	235	302	369
Walworth	16,873	844	1,181	1,519	1,856
Washburn	2,836	142	199	255	312
Washington	23,085	1,154	1,616	2,078	2,539
Waukesha	70,408	3,520	4,929	6,337	7,745
Waupaca	9,865	493	691	888	1,085
Waushara	4,094	205	287	368	450
Winnebago	27,236	1,362	1,907	2,451	2,996
Wood	13,879	694	972	1,249	1,527
Wisconsin	**999,680**	**49,984**	**69,978**	**89,971**	**109,965**

Source: Estimation methodology of Children with Severe Emotional Disturbances, Federal Register/Vol. 63 No. 137/Friday, July 17, 1998.
* Source: U.S. Census Bureau, County Population Estimates by Selected Age Categories and Sex: July 1, 2002
** Wisconsin, with one of the lowest poverty rates for children (10.9 percent), is placed in Group A.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 2

Goal:	**To increase the number of children who have access to services in the public mental health system. (National Outcome Measure)**
Objective:	Increase by 1 percent annually the number of children served through the public mental health system in CY 2005 and CY 2006.
Population:	Children with SED and their families.
Criterion:	Mental Health System Data Epidemiology.
Brief Name:	Increase access to services.
Indicator:	Number of children ages 4-17 receiving mental health services in CY 2005 and 2006.
Measure:	*Numerator:* Number of children ages 4-17 receiving services through the public mental health system in CY 2005 minus the number of children ages 4-17 receiving services through the public mental health system in CY 2004. *Denominator:* Number of children age 4-17 receiving services through the public mental health system in CY 2004.
Source of Information:	Human Services Reporting System (HSRS) data.
Special Issues And Strategies:	The data to monitor Wisconsin's progress on access to care for children will be taken directly from Basic Data Table 2A that we are required to report in the annual Implementation Report.
Significance:	Children's mental health services are expanding in Wisconsin, but increased access to a comprehensive public mental health system is still an important issue for children and their families.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **CY 2005-2006**

Population: **Children with SED and their Families**

Criterion: **Mental Health System Data Epidemiology**

Performance Indicator: Increase access to services	**CY 2002 Actual**	**CY 2003 Actual**	**CY 2004 Projected[1]**	**CY 2005 Target**	**CY 2006 Target**
Value:	-4.2%	-0.3%	14.8	1%	1%
Numerator:	13,726 - 14,326	13,682- 13,726	15,710 - 13,682		
Denominator:	14,326	13,726	13,682		

1. Milwaukee County data for CY 2004 is incomplete. Complete data will not be available until 9/15/05. This indicator table will be resubmitted after we have received their data.

Action Plan

Wisconsin will use a number of different methods to increase the number of children with access to services in the public mental health system. These methods will be used in both FFY 2006 and FFY 2007. First, the new CCS benefit will provide an expanded choice of MA-funded mental health services. Increasing the number of counties that have a CST will also bring these wraparound services to more children in areas where these services do not already exist. Implementing telepsychiatry will also provide mental health services in rural parts of the state where these services are currently unavailable.

In addition, expansion of crisis services will increase the number of children with access to these services. Wisconsin dedicated $500,000 of state GPR funds for five regional multi-county projects to expand crisis services. The state also has a half-time consultant providing training and technical assistance to counties to assist them in developing crisis programs for children.

Criterion 3: Children's Services

DHFS is responsible for the coordination of children's mental health services in Wisconsin, supported by the Departments of Public Instruction, Workforce Development, and Corrections. BMHSAS is the designated mental health authority. It assumes major responsibility for the planning, monitoring, technical assistance, and training for counties delivering mental health services.

DHFS is an umbrella organization and contains all child and family-serving agencies except for those within the Departments of Public Instruction and Workforce Development, and the Division of Juvenile Corrections, which is part of the Department of Corrections. The CST Initiative is intended to blend what were once disparate funding streams and efforts; it is a partnership between MBHSAS and the Division of Child and Family Services (child welfare), along with other stakeholders at the state and local level. The goal is to implement a collaborative systems change by serving children and their families who are involved in one or more systems including mental health, substance abuse, child welfare, and/or juvenile justice. Expanded emergency crisis services and prevention/early identification activities offer additional opportunities to reduce hospitalization and recidivism.

Strategic planning, development, and implementation with measurable outcomes for goal attainment all help define priorities and future direction for expanding Wisconsin's public mental health system of care for children with SED. The primary goal for these programs is to provide a wraparound model of service delivery with interagency collaboration and active parent/family participation. These efforts support and reinforce the focus on family-centered and community-based service delivery. This focus on family-centered services in wraparound programs is in accordance with Goal 2 of the NFC, which states that a transformed mental health system is consumer and family driven.

The Department, the Wisconsin Council on Mental Health, parents, families, advocates, providers, and other system partners are working together to expand delivery of services using a wraparound model statewide. Planned efforts include cross-system training on issues of substance abuse, trauma, suicide prevention and awareness, emergency crisis services including crisis stabilization, and mental illness.

Wraparound Services

The ISP program in Wisconsin dates back to 1989 with the adoption of Wisconsin Act 31, which created section 46.56, Wisconsin Statutes. Section 46.56 provided a structure for county programs to develop ISPs for children with SED. Criteria for ISP participation include: being under 18 years of age, having SED per state and federal definitions, being involved with two or more service systems, and being at risk of out-of-home placement.

There are 40 counties with wraparound programs for children with SED, consisting of a mix of small integrated services, large public managed care programs, and federally-funded projects. Based on 2003 data, the state's largest wraparound system of care, the nationally acclaimed Wraparound Milwaukee, served 905 primarily court-referred children and families. Children Come First of Dane County, the state's second largest wraparound system of care, served a total of 263 children and families in 2002. These two managed care initiatives are funded with a combination of Medicaid and county administered funds. The map on the following page shows the number of Wisconsin wraparound programs serving children with SED. In 2006 twenty-nine counties will receive Mental Health Block Grant funding for

wraparound services in addition to the 11 counties that receive a mix of financial support such as Substance Abuse Block Grant funding, funding from the Division of Children and Families, and state GPR.

Process to Receive Services within an Integrated Services Project

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

Each project has a screening and review process designed to evaluate the appropriateness of referral, using guidelines developed by its coordinating committee. The service coordinators continue the process by facilitating the organization of a child and family team made up of family members, other natural supports (friends, clergy, etc.), mental health and other professionals such as teachers, social workers, and/or AODA counselors, and advocates. The assembled team then creates a plan of care utilizing an array of services. New services may be added to the care plan as needed to meet new needs. Any change in the plan requires team approval. A family's needs may be outside traditional mental health services. For example, if a pressing need of the family is to secure housing, then a housing search becomes the focus of the team's and the service coordinators efforts. Flexible funding may be used to complete the plan. There is growing recognition that alleviating family stress is critical to achieving positive outcomes.

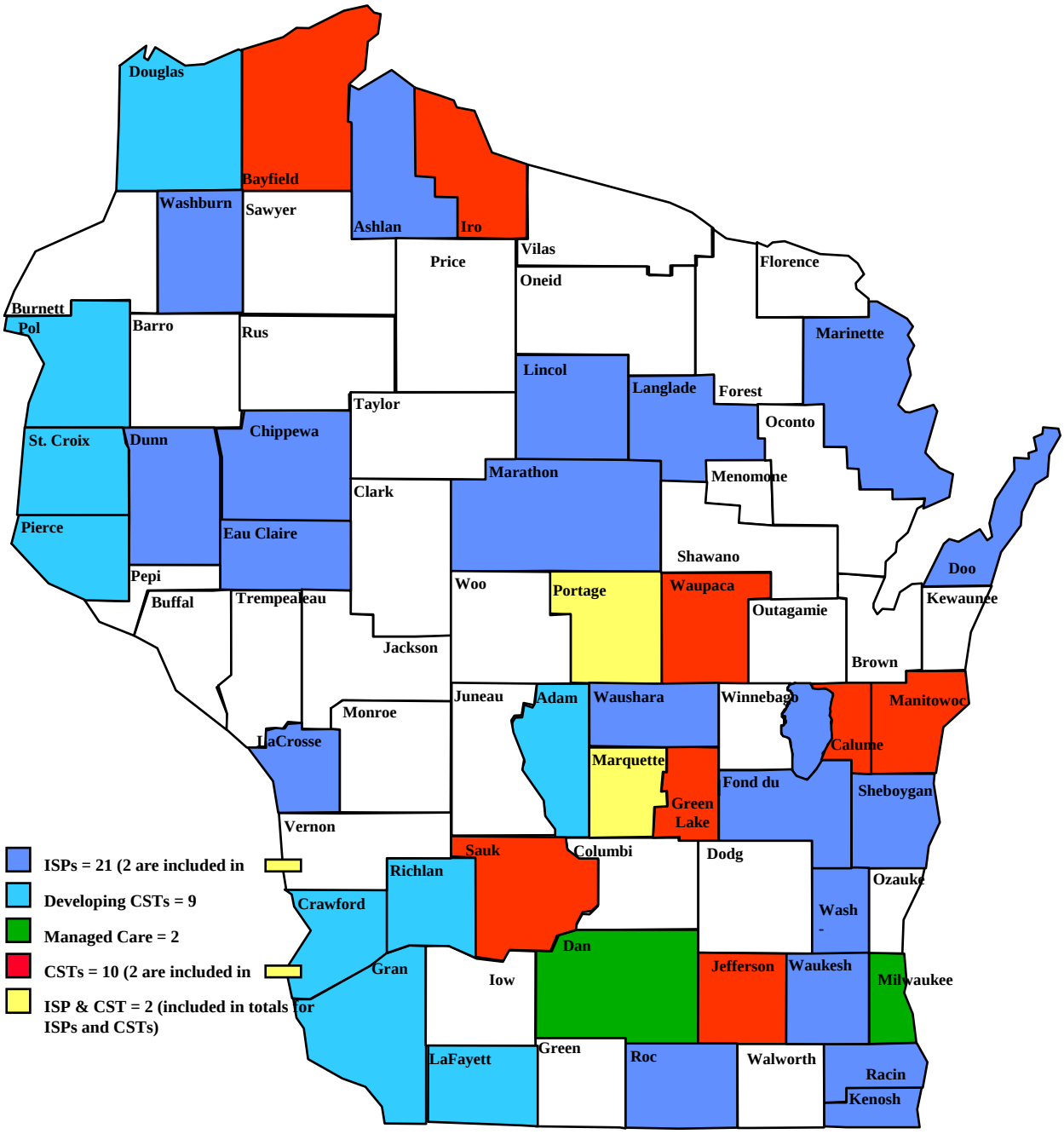
The Eight Key Components Evaluation Tool

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

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

Wisconsin's Collaborative Systems of Care for Children & Families

(Updated April 2005)



Wraparound Program Population Profile and Outcome Measures

Preliminary analysis of wraparound program data has allowed the Bureau to compile encounter data across the wraparound counties. Data consultants have begun to draft preliminary reports on client outcomes and quality of service. However, multiple issues were discovered in the process. Data is currently collected through a standalone PC database. As part of the DIG, a gap analysis was completed

to determine whether the data collected through the standalone system could be collected through the existing HSRS data system. The DIG was used in part to propose ways to improve capability for data analysis and evaluation. The data reports could be used to provide feedback for quality improvement within the ISP counties.

Program directors were asked to complete a survey on how to proceed for data system improvement. The survey information and input will assist in determining the best method for data collection and integration. The goal remains improved state and county reporting capabilities on outcome indicators, performance measures, evaluation reports, service delivery, long-term planning, and resource allocation.

The number of children under 18 years old with a diagnosis of SED, including those in a wraparound program, who require intensive or ongoing care are reported in the HSRS Mental Health Module. The largest concentration of children served occurs within the urban areas of Milwaukee, Dane, Brown, and Rock counties. This concentrated population accounts for over one-third of the total number served.

Currently, wraparound programs report standardized measures such as Child and Adolescent Functional Assessment Scale, or Restrictiveness of Living Environment Scales, which allow for program evaluation and monitoring. The full annual report on ISP outcomes will be submitted with the Implementation Report in December 2005. Over the next two years, 2006 and 2007, we anticipate not only maintaining the existing 40 counties but add a minimum of 2 funded sites each year and begin training and technical assistance for development in 3 additional counties and one Native American tribe.

Substance Abuse Services

Wisconsin provides a range of AODA-certified services, including prevention, emergency outpatient, four levels of detoxification, five levels of rehabilitation, and one level of narcotic treatment services. There are 111 service agencies that provide a specialty service in working with adolescents/ youth AODA treatment. Treatment modalities range from topical group work, one-on-one counseling, family counseling, and educational opportunities to experiential interventions such as a ropes team course.

Youth enter the AODA treatment service system through a variety of sources. The two predominant referral bases are local community schools and local law enforcement. The DPI completes an annual survey of Wisconsin students to determine current trends in drug use and intervention strategies. In 2002, survey results showed Wisconsin students had demonstrated successful outcomes in a peer development model. All local criminal justice systems develop their own community-specific juvenile court intervention services.

BMHSAS is targeting screening, early intervention, assessment, and linkages for adolescents referred to the juvenile justice system. There are nine contracts operating within eleven county human services delivery systems in Wisconsin, located in counties with wraparound services. These counties are Milwaukee, Kenosha, Fond du Lac, Outagamie, Portage, Dunn, Eau Claire, Dane, and Forest/Oneida/Vilas. All of the sites utilize the POSIT screening tool and complete appropriate referrals for further assessment and treatment services based on the initial screen, supporting collateral information, and the availability of services. The tool flags assessment areas for mental health issues, AODA issues, family dysfunction, juvenile delinquency, and education issues or difficulties. It is anticipated that the Bureau will create additional cross training opportunities and enhanced integrated provision of mental health and substance abuse services to better serve youth that engage in substance abuse and dependency and also have mental health issues.

Educational Services

Wisconsin continues to work collaboratively to provide educational services to children with SED. DPI continues to work on several issues across multiple systems to improve the success of children with special educational needs who have mental illness or substance abuse disorders. Immediate efforts for focused cooperation can be seen in work through the CST in the eight new CST counties and in the other wraparound counties. DPI administers the Wisconsin Youth Risk Behavior Survey (YRBS) every two years. In 2003 the survey was administered to 2,121 students in 50 public high schools and the Wisconsin data were compared to the National YRBS data to analyze trends and comparisons. As reported in the survey, the percentage of students who said that they considered suicide had dropped from 27 percent in 1993 to 20 percent in 2003. Eight percent of students reported that they had attempted suicide in the twelve months prior to the survey.

DPI staff continues to work closely with the BMHSAS in many areas. Training occurs through the CESAs, school districts, conferences, and other professional training. A curriculum for identification of mental illness and other emotional/behavioral issues has been developed with emphasis on prevention and early intervention.

Wisconsin School-Based Suicide Prevention Initiative

The 2002 annual DHFS Death Review Summary finds that suicide was the second-most common cause of death among 15- to 24-year-olds in Wisconsin. It accounted for 91 deaths (11.5 percent), and exceeded the national rate of 9.9 percent of deaths.

State law requires public schools to provide content-specific suicide prevention instruction addressing:

- decision-making skills,
- positive emotional development,
- causes and signs of suicide,
- the relationship between youth suicide and alcohol/substance abuse, and
- community prevention and intervention services [Wis. Stat. 118.01(2)(d)(7)].

In support of this requirement, state law also requires the provision of training and technical assistance addressing positive emotional development and the detection of suicidal tendencies and intervening with individuals in crisis.

In addition to the six joint DHFS/DPI suicide prevention grants discussed in Criterion One, DPI contracted with Leona Eggert, a leading national expert in youth suicide prevention, to conduct a literature review and develop a toolkit to help schools improve their school-based suicide prevention efforts.

Professional development is available upon request to help school staff and their community partners:

- understand the nature and scope of youth suicide in Wisconsin,
- understand the components of a comprehensive, school-based suicide prevention program,
- assess their current suicide prevention efforts and learn how to build on current prevention activities to improve these efforts,
- develop the skills to provide classroom instruction, and
- understand where they can obtain additional training, if necessary.

Medical and Dental Services

The Wisconsin Managed Care Context

Wisconsin has a strong track record in designing and managing Medicaid managed care programs. Health and long-term care represent over 80 percent of the state's Medicaid budget. Persons receiving Social Security Insurance (SSI) automatically qualify for Medicaid services. Relevant examples of Wisconsin programs include those summarized below.

BadgerCare

BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185 percent of the federal poverty level through a Medical expansion under Titles XIX and XXI. In state fiscal year 2005 there were 30,883 children and 64,949 parents enrolled in BadgerCare. The program goal is to fill the gap between Medicaid and private insurance without supplanting private insurance. BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid, and recipients' health care is administered through the same delivery system. No asset test is required. Premiums are collected through wage withholding or an alternative automated system.

Mental Health Managed Care Programs for Children

Wisconsin has two Medicaid managed care programs for mental health services for children who have SED and are at risk for out-of-home placement: Children Come First (Dane County) and Wraparound Milwaukee. The programs are managed by DHCF.

Dental Services

Access to dental services continues to be a problem for Medicaid recipients in the state. Dental care services were given an increased focus during contract negotiations with certain HMOs that cover dental services to increase access to those services. As of March 2003, dentists do not need to receive prior authorization for some dental procedures (i.e., root canals) for recipients under the age of 21. For children and youth who have SED and may be on psychotropic medications, a lack of dental care could have serious side effects. Poor dental care affects children's nutrition, growth, development, and well-being.

Juvenile Justice Services

In 2002, BMHSAS began delivering tools and system development to support Wisconsin's mental health and substance abuse providers in recognized trauma symptoms for Wisconsin's youth population. The Wisconsin Office of Justice Assistance funded a grant to cover the costs of developing the tools. This partnership created a training opportunity for both the Juvenile Justice pilots and CST Initiative county sites in the Sidran Foundation model of trauma symptoms identification and treatment model. This collaboration made possible the development of a Wisconsin version of the automated POSIT that identifies trauma indicators, as well as, AODA, mental health, school, delinquency, and family issues. While implementation did not begin until January 2004, it is hoped that the data representing approximately 3,000 youth at first entry into the juvenile justice system will help to guide the state in future collaborative efforts.

The Department of Corrections' (DOC) Southern Oaks Girls School began operating the Stepping Up-Mental Health Unit (SU-MHU) in January of 2000. The unit is funded through the Juvenile

Accountability Block Grant, which allowed DOC to test the effectiveness of providing onsite intensive mental health services for girls in a correctional setting. There have been 95 admissions to the SU-MHU program through January 2005. Girls admitted to the program have displayed dramatically improved institutional adjustment and post-release outcomes compared to a prior comparison group of girls.

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

Child Welfare Services

Wisconsin's Child Protective Services (CPS) program is state-supervised and county-administered. Alleged child maltreatment is reported to county human/social services departments in all counties except Milwaukee County, where it is reported to the state Bureau of Milwaukee Child Welfare. The role of the department is to supervise the county programs and assure that there are statewide policies and procedures that support the goals of child protective services: child safety and stability of the family. The focus of a CPS assessment is to assure child safety and to work with the family to determine whether the child and family are in need of any services. If the report is accepted by the agency for assessment, a caseworker will assess the situation and work with the family to determine what, if anything, must be done to protect the child and help the family. Services available to help the family and the child include counseling, in-home services, assistance or training in home and financial management, parent education, and self-help groups.

A September 2002 UCLA Center for Healthier Children, Families, and Communities study reports that numerous studies have shown that between 50-80 percent of children in the child welfare system have mental health care needs. This study also indicates that a higher prevalence of mental health problems among children in foster care results from the trauma associated with high-risk and often dysfunctional family settings, from acute reactions to the trauma of being placed in foster care, and from being separated from the biological parent. This study also indicates that children in foster care use 15-20 times as many mental health services than other low-income children covered by Medicaid. Recommendations by the Child Welfare League of America, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry suggest that all children should receive a mental health screening when placed in foster care and receive a comprehensive mental health assessment by a mental health professional as part of a comprehensive evaluation within a month thereafter. BMHSAS is working with DCFS to develop a proposal to provide mental health screens for children in the child welfare system.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 3

Goal 1:	**Decrease the rate of readmission to psychiatric hospitals within 30 days. (National Outcome Measure)**
Objective:	Decrease the rate of readmission to psychiatric hospitals within 30 days by 0.5 percent annually in CY 2004-2006.
Population:	Children and their families.
Criterion:	Children's Services.
Brief Name:	Decrease psychiatric hospital episodes within 30 days.
Indicator:	The percentage of children discharged from all state and county psychiatric hospitals in CY 2004 who are readmitted within 30 days.
Measures:	*Numerator:* The number of children discharged from all state and county psychiatric hospitals in CY 2004 who are readmitted within 30 days. *Denominator:* The number of children discharged from all state and county psychiatric hospitals in CY 2004.
Sources of Information:	HSRS and Medicaid data.
Special Issues And Strategies:	The data to monitor readmissions to psychiatric hospitals for children will be taken directly from Developmental Data Table 21, which we are required to report in the annual Implementation Report.
Significance:	Community-based treatment is at the core of the service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of the wraparound approach in the community.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **CY 2005-2006**

Population: **Children and their Families**

Criterion: **Children's Services**

Performance Indicator: Decrease psychiatric hospital episodes within 30 days	**CY 2002 Actual**	**CY 2003 Actual**	**CY 2004[1] Projected**	**CY 2005 Target**	**CY 2006 Target**
Value:	8.2%	7.1%	6.6%	6.1%	5.6%
Numerator:	218	175			
Denominator:	2,663	2,462			

1. Data on CY 2004 readmissions will be available at a later date. Because this indicator tracks readmissions for all discharges up through the end of CY 2004, data from the following year is necessary. Wisconsin will submit the required data as soon as it is available.

Action Plan

Wisconsin projects an annual decrease of one-half of one percent in the readmission rate over the FFY 2006-2007 period. While Wisconsin does not have a program initiative specifically targeted at reducing readmission to inpatient hospitals, there are a number of programs that will likely have an impact on this indicator:

- The new CCS benefit will expand the availability of outpatient MA-funded mental health services. In FFY 2006 we project that there will be 16 counties with certified CCS programs, and 24 counties with certified programs in FFY 2007.
- Increasing the number of crisis programs through the five new multi-county initiatives will also serve to reduce the number of inpatient placements, including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years.
- Finally, increasing the number of counties that are operating a CST will reduce the number of out-of-home placements by expanding the availability of wraparound services. Wisconsin projects that we will add two additional counties that operate a CST program in FFY 2006 and in FFY 2007.

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

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 3

Goal 2:	**Decrease the rate of readmission to psychiatric hospitals within 180 days. (National Outcome Measure)**
Objective:	Decrease the rate of readmission to psychiatric hospitals within 180 days by at least 0.5 percent annually for CY 2004-2006.
Population:	Children and their families.
Criterion:	Children's Services.
Brief Name:	Decrease psychiatric hospital episodes within 180 days.
Indicator:	The percentage of children discharged from all state and county psychiatric hospitals in CY 2004 who are readmitted within 180 days.
Measures:	*Numerator:* The number of children discharged from all state and county psychiatric hospitals in CY 2004 who are readmitted within 180 days. *Denominator:* The number of children discharged from all state and county psychiatric hospitals in CY 2004.
Sources of Information:	The HSRS and Medicaid data.
Special Issues And Strategies:	The data to monitor readmissions to psychiatric hospitals for children will be taken directly from Developmental Data Table 21, which we are required to report in the annual Implementation Report.
Significance:	Community-based treatment is at the core of the service delivery philosophy. Reducing readmissions to psychiatric hospitals reduces costs and facilitates the use of the wraparound approach in the community.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **CY 2005-2006**

Population: **Children and their Families**

Criterion: **Children's Services**

Performance Indicator: Decrease psychiatric hospital episodes within 180 days	**CY 2002 Actual**	**CY 2003 Actual**	**CY 2004[1] Projected**	**CY 2005 Target**	**CY 2006 Target**
Value:	16.9%	15.6%	15.1%	14.6%	14.1%
Numerator:	450	384			
Denominator:	2,663	2,462			

1. Data on CY 2004 readmissions will be available at a later date. Because this indicator tracks readmissions for all discharges in CY 2004, data from the following year is necessary. Wisconsin will submit the required data as soon as it is available.

Action Plan

Wisconsin projects an annual decrease of at least one half of one percent in the readmission rate over the FFY 2006-2007 period. While Wisconsin does not have a program initiative specifically targeted at reducing readmission to inpatient hospitals, there are a number of programs that will likely have an impact on this indicator:

- The new CCS benefit will expand the availability of outpatient MA-funded mental health services. In FFY 2006 we project that there will be 16 counties with certified CCS programs, and 24 counties with certified programs in FFY 2007.
- Increasing the number of crisis programs through the five new multi-county initiatives will also serve to reduce the number of inpatient placements, including re-admissions. The Department has committed to funding these multi-county initiatives using state GPR funds for a minimum of three years.
- Finally, increasing the number of counties that are operating a CST will reduce the number of out-of-home placements by expanding the availability of wraparound services. Wisconsin projects that we will add two additional counties that operate a CST program in FFY 2006 and in FFY 2007.

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

Criterion 4: Targeted Services to Rural and Homeless Populations

Mental Health Needs and Services for the Homeless Population

No accurate estimate of the number of homeless children exists due to the practical difficulties in locating and tracking homeless families. One source of information in Wisconsin is DPI. Starting in the 2004-05 school year, the federal Department of Education requires states to do an annual count of homeless students. DPI surveyed Wisconsin's school districts, which reported that they had 5,119 homeless students enrolled. The actual number is likely higher, as this was the first year the survey was done and not all school districts were aware of the need to collect this data.

School staff may encounter two general situations regarding homeless families: the family who is temporarily homeless, and the frequently mobile homeless family whose children have attended several schools in one or more districts. The child who has experienced chronic homelessness will often present greater needs, including assistance with mental health services.

Families with children are the fastest growing segment of the homeless population. Domestic violence is one of the most common reasons for women and their children becoming homeless. Children are homeless on average ten months at a time. Twenty five percent of homeless children are homeless more than once. Homeless children are more likely to live in situations with adults who experience mental illness, substance abuse, and domestic violence. These and other stressors associated with homelessness and poverty impact the psychosocial wellbeing of children. These environmental and psychosocial stressors undermine normal development. Screening in shelters has identified more developmental lags in homeless pre-school children, while academic and behavior problems are more common among homeless school-age children. Homeless children also display a higher rate of depression and emotional behavior problems, including aggressive behavior such as hitting other children or adults, frequent temper tantrums, frequent stubborn, sullen or irritable behavior.

Because of the psychological and cognitive difficulties they face, and the stress of living in shelters, homeless children often need special counseling and other forms of assistance. Categorical or "silo" funding streams make it difficult to serve the multiple needs of children who are homeless and have mental illness. Many have more than one agency involved in their lives, requiring the creative coordination of many funding sources available through separate service providers. ISP, CST or managed care programs that provide wraparound services to children with SED help to address these problems. In 2005, there were 40 counties with wraparound projects. These programs can help coordinate school staff, counselors, shelter workers, health care and family support services in a comprehensive effort to ensure that children's basic needs are met. They may also help the homeless child's parents negotiate the daunting procedures and requirements of service agencies. Comprehensive approaches to serving homeless children can be geared to intervene with the entire family of the homeless mentally ill child.

In addition to wraparound services 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, DDES 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 with 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.

Mental Health Needs and Services for the Rural Population

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.

Wisconsin's definition of a rural area is based on the definition of an urban area. According to the State and Metropolitan Area Data Book (5th Edition 1997 – 1998, US Department of Commerce, Economics and Statistics Administration, Bureau of the Census), a rural area is defined as county not classified as a "metropolitan area." 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 or 19 percent of the 72 counties are urban, while the remaining 58 counties or 81 percent are rural counties. 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 urban areas of Wisconsin encounter access issues due to the uneven distribution of the health care workforce and a fragile health care infrastructure. Fifty of Wisconsin's 72 counties have communities that have been designated as mental health professional shortage areas by the federal Health Resources Service Agency. These include parts of larger cities, large numbers of rural areas throughout the state, most tribal populations, and low-income populations. Additionally, there is a shortage of providers who will supply health care to low-income and Medicaid populations.

Many counties in Wisconsin do not have mental health providers such as psychiatrists or psychologists. A number of counties in rural Wisconsin have a difficult time recruiting psychiatrists to deliver services, 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 financial resources just for travel time without the psychiatrist even seeing a consumer. Wisconsin is allowing Medicaid-covered services to incorporate telehealth technology to address this problem.

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 of the use of technology to increase access to services. Telehealth 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, natural supports, etc.

Telehealth 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. Telehealth 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, inpatient, etc. All staff employed by these programs may provide services via telehealth, provided they have received the necessary training and meet program certification standards. The DHCF will reimburse for Medicaid-covered services delivered via telehealth in the same way it reimburses for face-to-face contacts provided that certain requirements are met.

Other Wisconsin initiatives that help provide for the needs of rural mental health consumers include:

- collaborative efforts to work with the Rural Health Provider Network,
- exploration of partnerships with the Division of Public Health and with the Rural Health Network to increase focus to the mental health needs of farm families and other persons,
- expanding consumer and family support networks and consumer directed services,
- increasing consumer and family participation on state/county/agency planning boards, advisory boards and workgroups,
- providing start-up funding for rural counties without CSPs, and
- expanding the service array statewide such as with the implementation of CCS. This MA benefit will provide for an array of psychosocial rehabilitative services to individuals across the life span to meet needs that are more intensive then outpatient services but less intensive than required for treatment in CSPs.

The Bureau has also discussed homeless issues with the wraparound project directors at their quarterly meetings. In 2006 and 2007 the Bureau will be working closely with DPI and the Coordinator for the Education for Homeless Children and Youth Program to acquire a more accurate accounting of the homeless population of school age children. With the expansion of CSTs, multi-county crisis programs and increased knowledge of staff working in wraparound programs about the issues of homeless children in their community's, additional children will be identified and served in the next two years.

Key Challenges

Wisconsin's community mental health system has resource limitations. Certified crisis programs exist only in about a third of the counties, which limits some of the initial outreach and services to people and shifts this important contact to law enforcement. Another challenge is access to mental health and Alcohol and Other Drug Abuse (AODA) treatment services including integrated services for children with co-occurring disorders. In rural areas there are a limited number of services and providers. In low population density counties, public mental health programs have challenges with availability of specialty psychiatric and psychological services, such as assessment, evaluation, appropriate and effective treatment, medications, and prescription review for children, adolescents, and young adults. Transportation is also a challenge; travel time to reach services is often considerable; the lack of availability of public transportation limits consumers and their families' ability to attend peer and family support programs.

Opportunities

The BMHSAS is providing $541,700 per year of general-purpose revenue (GPR) hospital diversion money to expand crisis stabilization programs across the state's five regions. The funds will be available for several years, giving the counties the opportunity to develop certified programs, so they can bill MA for the crisis stabilization services they provide. The counties are taking a multi-county approach to developing services for children as well as adults, in their region. Through this regional approach, as counties become certified for emergency crisis services they will also be able to provide additional mental health resources for families with children with SED living in rural counties. Thirty counties in six regions are receiving these funds.

The BMHSAS is working with local communities, consumer and family groups, as well as other agencies to expand the capacity to better serve the needs of rural mental health consumers and their families. Rural counties benefit from the CST Initiative and ISP, which offer technical assistance and training opportunities on wraparound service delivery across multiple systems. In 2005 eight new CST sites received funding. Another solution to expand service delivery is to utilize telepsychiatry video conferencing for mental health reviews, assessments and evaluations.

Homelessness among families is increasing and the growth in the size of Wisconsin's homeless population is the result of many factors. The problem may appear more dramatic in cities, but it can be just as devastating in rural areas where there are few, if any services and often no emergency shelter facilities. Wisconsin's DPI has awarded almost $500,000 to ten school districts across the state with McKinney-Vento Homeless Assistance funds to assure that all homeless children and youth have equal access to education. Eight of these ten counties also have ISPs and CSTs, so the opportunities to better collaborate with the funded districts and DPI are available.

Wisconsin has focused on meeting the needs of its rural and homeless children with SED and their families in the following ways:

- the use of teleconferences,
- providing educational materials on mental health, mental illness, transition and recovery-oriented services, and parent support, advocacy and self-empowerment agencies,
- collaborative efforts to work with the Rural Health Provider Network, to increase the focus on the mental health needs of farm families, children with emotional disorders, and other emerging rural issues,
- expansion of certified emergency crisis services,
- expanded use of telehealth,
- collaboration with DPI to address the mental health needs of homeless children,
- increased consumer and family participation on planning boards, advisory boards, including the Mental Health/Alcohol and Other Drug Abuse Redesign Initiative, and
- CST Initiative programs for children with SED.

Data collection, evaluation, and analysis of performance outcomes will provide more information about how best to meet the mental health needs of rural and homeless children. The BMHSAS issued a numbered memo to all counties in Wisconsin indicating that services to the homeless were to be the priority for mental health block grant funding for FFY 2005. The memo also instructs county staff to be sure to accurately report an individual's homelessness in the HSRS. By directing county staff to make services to the homeless mentally ill and the data collection regarding those services a priority, BMHSAS will start to improve its understanding of the mental health needs of homeless children in the state.

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 4

Goal 1:	**Improve access to telehealth consultation in rural areas.**
Objective:	Increase the number of certified telehealth systems in rural counties by 3 annually for FFY 2006-2007.
Population:	Children with SED and their families.
Criterion 4:	Targeted Services to Rural and Homeless Populations.
Brief Name:	Implement telehealth.
Indicator:	Increase the number of certified telehealth systems in rural counties by 3 annually for FFY 2006-2007.
Measure:	The number of rural counties with certified telehealth systems in place to serve children in FFY 2006-2007.
Source of Information:	Certification data from the state.
Special Issues and Strategy:	Telehealth is a new initiative in Wisconsin in 2004. Establishing telehealth services is a long process and it is undetermined yet what type of entities will participate. Counties, regions, or individual providers could join the initiative as participants who provide telehealth. Each entity must be certified to provide and operate the proper telecommunication equipment for consumers. The certification process will take time.
Significance:	A majority of counties in Wisconsin can be classified as rural. Access to psychiatric services is a gap in Wisconsin's mental health system. This indicator is in accordance with NFC Goal 6.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **FFY 2006-2007**

Population: **Children with SED**

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

Performance Indicator: Implement telehealth	**FFY 2003 Actual**	**FFY 2004 Actual**	**FFY 2005 Projected**	**FFY 2006 Target**	**FFY 2007 Target**
Value:	Not applicable	0	3	6	9
Numerator:					
Denominator:					

Action Plan

Wisconsin secured approval for payment under MA for mental health services delivered using telehealth technology in September 2004. Making the services reimbursable through MA will allow more children to take advantage of the services and thereby make providers more willing to apply for certification. One site was approved in February 2005 and two more sites are pending approval in CY 2005.

In FFY 2006, Wisconsin will certify three rural counties for MA payment of mental health services delivered using telehealth technology.

In FFY 2007, Wisconsin will certify an additional three rural counties.

Criterion 5: Management Systems

The BMHSAS is the designated mental health authority. The BMHSAS 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 BMHSAS has primary responsibility for development and implementation. The BMHSAS' resources to implement the State Mental Health Plan include the resources of the DDES and the DHFS.

Financial Resources, Staffing, and Training

BMHSAS Staff (Mental Health Authority)

As part of a statewide effort to improve efficiency and streamline government, five positions were cut in BMHSAS. The BMHSAS currently consists of four Sections and 36.9 full-time equivalent (FTE) positions including the Director and the Director's Program Assistant (see organizational charts, Appendix I).

In FFY 2006 and FFY 2007, the Mental Health Services and Evaluation Section will be 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 federally-required Wisconsin Council on Mental Health will also be provided by this section. Some integrated MH/AODA functions will also be the responsibility of the Mental Health Services and Evaluation Section. The section will be responsible for mental health and substance abuse programming for the deaf and hard of hearing and the elderly populations and Pre-Admission Screening and Resident Reviews (PASARR). Finally, all evaluation 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 Evaluation Section will have 8.0 FTEs.

The Substance Abuse Services and Contracts Section will provide a focus for services and programs designed primarily for substance abuse consumers. Thus, substance abuse and prevention programs have been consolidated within this section from across the bureau and include oversight of the substance abuse administrative rules, Access to Recovery, methadone programs, the Intoxicated Driver Program (IDP), the injection drug use program, and HIV prevention. The Substance Abuse Treatment and Prevention Block Grant (SATPBG) will be administered from the Substance Abuse Services Section. The Substance Abuse Treatment and Prevention State Plan (SAPTPBG 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. In addition to consolidation of substance abuse programs, the Substance Abuse Services and Contracts Section will also include integrated contract and fiscal services for the entire bureau. Staff previously holding separate mental health and substance abuse contract and fiscal responsibilities will be integrated to streamline contracting and fiscal procedures for the bureau. The Substance Abuse Services and Contracts Section will have 11.0 FTEs.

The Integrated Systems Development Section will be responsible for mental health and substance abuse programs and services at both the systems-level and client-level. The section will have two units (which currently are sections) and a total of 15.9 FTEs. The Women, Youth, and Families Unit will have a Unit Supervisor that directly supervises the unit staff and reports to the Section Chief. The Section Chief will directly supervise the Systems Redesign Unit and will have overall responsibility for both units. The programs and services in this section either had an integrated MH/AODA focus in the past that will be strengthened or had a primarily mental health or substance abuse treatment focus that will benefit from a new integrated MH/AODA approach. Staff who previously worked on either mental health or substance abuse programs will now work together in this integrated section to lend their respective sets of expertise to a more integrated approach to service delivery, contract management, and technical assistance.

The Women, Youth, and Families Unit will address 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 will be to address the goals of the Governor's KidsFirst Initiative. For example, the Urban/Rural Women's AODA Treatment Project that serves women with substance abuse disorders or co-occurring mental health and substance abuse disorders will operate within this unit. 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 will be consolidated in this unit. Staff with mental health and substance abuse expertise will work together to strengthen existing integrated MH/AODA approaches and implement new integrated approaches where needed. Staff will provide contract monitoring, technical assistance, training, and programmatic guidance to the Integrated Service Projects, Coordinated Service Teams, and hospital diversion programs targeted for children with SED who may also have substance abuse disorders. The unit will also be responsible for the Milwaukee Child Welfare Initiative, 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 will also be responsible for the Milwaukee NEXUS program, implementing and monitoring the new CCS benefit, providing clinical consultation services for consumers with substance abuse and/or mental health disorders, and monitoring child and family advocacy activities.

The Systems Redesign Unit will be 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 Redesign 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 will be conducted through contracts and support to the Recovery Task Force. Unit staff will also be responsible for preparing counties for human service system disaster response and preparedness. Unit staff will also be 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 will reside in the Systems Redesign Unit as well as programs that target housing and coordinate with the Department of Commerce on homeless issues, particularly the PATH grant.

Contract Support

In addition to BMHSAS staff, the BMHSAS also relies on contract support to perform unique or specialized tasks. The BMHSAS uses MHBG funds to contract with WCCF to set up a children's mental health and a crisis conference annually. MHBG funds are used to contract with an individual who is an

expert in the development of CST initiatives for children. Other non-MHBG funded contracts have responsibilities in FFY 2006 include 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.

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 New Partnerships for Women Project continues to offer trauma training for both consumers and providers.

In October 2005, the BMHSAS will sponsor its first annual Mental Health and Substance Abuse Training Conference "Breaking New Ground" 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 BMHSAS 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 2006 and FFY 2007.

In North-Central Wisconsin, there was a Question, Persuade, and Refer (QPR) 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 2006 and FFY2007.

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 2005. 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 2006 and FFY 2007.

Training of Mental Health Service Providers

One major area of training offered to mental health service providers every year is on the principles and implementation of Recovery. The BMHSAS will fund a contractor to provide Recovery trainings and will continue to work with a Recovery Task Force to develop Recovery training curriculums for providers. One type of training to be offered is Recovery Awareness training which is the first step in orienting providers to the principles of Recovery. Practitioner Competency Training sessions will also be offered by the Recovery contractor to provide more in-depth training on implementing Recovery principles into providers' work. A third type of training, called Guided Reflections, will be offered to organizations as a whole on Recovery principles including providers, administrators, and case managers. A fourth and final training on Recovery for providers will be a recovery-oriented boundaries and ethics training for social workers. The Wisconsin Coalition for Advocacy (WCA) develops and provides some of these Recovery trainings and the National Alliance for the Mentally Ill (NAMI) is the primary contractor responsible for providing Recovery trainings.

The WCCF 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, three one-day conferences 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.

Trainings are also provided by BMHSAS contractors on dealing with women's trauma due to physical abuse, sexual abuse, and other sources of trauma. Providers will be trained in FFY 2006 on how to identify and treat women's trauma based on a curriculum that was developed in FFY 2004. In a related initiative, WCA staff provide informational trainings on the intersection between mental illness and domestic violence to service providers where needed throughout the state.

The BMHSAS also funds through a contract with the University of Wisconsin an annual Mental Health Teleconference Series. The Series will sponsor and produce 24 biweekly mental health teleconference training sessions for providers of mental health services throughout the state. Over 1,000 individuals registered as participating in FFY 2004. Mental health service providers from 80 towns and cities participated. The Series provided 3,261 credit hours of training for the year. The average number of persons on each teleconference was 136 and the evaluation scores averaged 4.3 on a 5.0 point scale (5.0 = excellent). The topics presented included recovery, crisis intervention, medications, smoking cessation, substance abuse, mental health and the elderly, mood disorders and other mental illness diagnoses, vocational rehabilitation, and risk assessment for persons who are suicidal.

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 Management and Technology (DMT) and the Office of Strategic Finance (OSF). Within DMT are various financial management functions, including accounting, purchasing, and information systems. The Office of Strategic Finance is responsible for budgeting. DDES negotiates and monitors contracts with the counties and with nonprofit organizations/vendors.

Contracts and Grants Management

Data management within the DMT 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. The DMT has reporting requirements; 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, non-profit 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 six-month or annual reports on their progress. Future plans for the BMHSAS' contracting practices in FFY 2006-2007 include the standardization of contract outcome data so it can be aggregated across contracts and all BMHSAS 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 BMHSAS staff monitors quarterly and semi-annual reports, which provide the basis for identifying and addressing given issues and outcome attainment. Vendors are required to undergo an annual audit from an auditor of their choosing and the results are submitted to OSF. The BMHSAS contract monitors work with OSF and the contractor when there are audit issues to resolve.

Revenues and Expenditures for Mental Health

Medicaid is the largest source of funding for mental health programming. The state GPR funding, along with county tax levy dollars, grant funds (MHBG, PATH, and the Robert Wood Johnson Foundation) 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 matching level. The state Medicaid match is approximately 40 percent. Other state and federal Medicaid funds represent amounts not subject to the 60/40 match. 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 Medicaid funds are used for inpatient and institutional facilities, while the majority of GPR and block grant funds are used for community/ residential services.

In addition to the Mental Health Block Grant funding, Wisconsin receives other federal funding to support Wisconsin's mental health service system. The PATH grant of $640,000 will be used to support mental health services for individuals who are homeless in four of Wisconsin's largest urban areas (responsibility for the PATH program will be moved to the Department of Commerce in SFY 2006). An additional $45,000 in state funds will be contributed to the four PATH programs. Another $142,200 from a CMHS Data Infrastructure Grant will be used to support the BMHSAS' capacity for data collection and reporting for the Mental Health Block Grant and other programmatic needs. Wait lists are reduced for CSPs by providing $1,000,000 of state funds for 21 counties. Another $1,270,000 of Medicaid funds will be used for PASARR screening activities throughout the state.

For the BMHSAS operations, a total of about $300,000 from the Mental Health Block Grant will be used to fund 5.9 FTEs within the BMHSAS. Another approximately $660,000 split between Medicaid and state revenues will be used to fund 10.5 FTEs. A total of $82,400 of the PATH grant is used by the Department of Commerce to fund one full-time position for providing training, technical assistance, and program development to the PATH counties. Another $50,000 will be spent from a Social Services Block Grant on 1.0 FTE. Another $1,260,000 from the Substance Abuse Block Grant and the state-funded Drug Abuse Program Improvement Surcharge will fund 19.4 FTEs. A total of 5.9 FTE positions are vacant.

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 2003, counties contributed approximately $201,967,925 for mental health services, an increase of 1.3 percent over 2002.

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. The Wisconsin Department of Health and Family Services 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 full range of mental health medications and in the past used prior authorization sparingly, thus allowing physicians and consumers access to the most effective medications,
- has increased reimbursement rates for outpatient services rates that had been extremely low and were a barrier to provider participation,
- CCS benefit will provide reimbursement for community psychosocial rehabilitation services, and
- availability of MAPP for individuals with disabilities who return to work and are no longer eligible for Medicaid.

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 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 (NOMS) 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 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 from FFY 2005-2007 for $142,200 per year. Wisconsin is developing the data infrastructure necessary to meet the requirements of the CMHS Mental Health Block Grant 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 BMHSAS is preparing to move to a web-based information system in the next three years supported in part by funding from the Data Infrastructure Grant.

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 Mental Health Block Grant. 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 Redesign Data Systems

The Mental Health/AODA Redesign Initiative funded by the MHBG from FFY 2003-2005 has developed two data collection components that the BMHSAS will want to continue to fund and support in FFY 2006-2007. One of the components is an interview instrument called the Recovery-Oriented System Assessment (ROSA). The ROSA interview collects information directly from consumers about the achievement of their self-defined Recovery outcomes in their lives. One way of determining the quality of services and supports is the degree to which services or systems assist individuals to achieve and maintain these outcomes in their lives. The ROSA interview determines the degree to which consumers have reached their desired outcomes and to what degree the mental health system has facilitated consumers' progress towards their outcomes. A team consisting of a trained consumer and another interviewer conduct the interviews. Based on the information from the interviews and a guided decision-making process, the interviewer determines the overall absence or presence of an outcome. The plans for the ROSA are to incorporate it as a model data collection instrument for counties to use in their quality improvement processes. The ROSA data can provide valuable information on the implementation of the Recovery process.

Wisconsin also developed a MH/AODA Functional Screen through the Redesign Initiative 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 to generate a screen result. 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/AODA disorders. For consumers who may have a primary AODA diagnosis, the MH/AODA Functional Screen is linked to another AODA screening tool that providers can also use. The plan for the use of the Functional Screen in FFY 2006-2007 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 program in Wisconsin. The staff encourages its use to determine need for CSP services. Data from the MH/AODA Functional Screen will be imported into the MH/AODA 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 and crisis services provided in the community to individuals and families experiencing heightened emotional distress and/or behavioral disorder. The aim 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 Bureau of Quality Assurance when certifying and re-certifying crisis programs. Currently almost all counties are certified for basic emergency crisis services, and 35 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 2 years there will be at least 43 crisis programs certified under HFS 34 Subchapter III.

The Crisis Intervention Network

The Crisis Intervention Network is a group of state agency staff including BMHSAS 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 RFP 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 $541,700 available per year of state GPR funds for this initiative. Funding for one additional Multi-County Crisis Program (Milwaukee/Waukesha) was made available in 2005. As other funding becomes available the remaining two proposals will be funded. 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, 21 are certified HFS 34 Subchapter III and eight more will become certified within two years.

Crisis Intervention Conference

The annual Crisis Intervention Conference will occur in September 2005. 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. 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 2006-2007

After a $50,306 reduction in FFY 2005, Wisconsin's final Mental Health Block Grant award was **$6,814,203**. A proportional reduction ($3,003) was absorbed in the BMHSAS' operations budget and the remainder of the reduction was absorbed from Wisconsin's MH/AODA Redesign Initiative funding. At the time of the writing of this application, Wisconsin had not yet been notified by CMHS of its grant award for FFY 2006. Thus, the expenditure plan below for FFY 2006-2007 is based on the FFY 2005 award amount.

FFY 2006 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 2006 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 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 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 recent tradition of using approximately 13 percent of its MHBG for this purpose. In a June 2005 federal MHBG review, it was noted that Wisconsin's funding and programmatic activities in this area are one of its top strengths. 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.

$489,795 Mental Health/AODA Redesign Initiative

The MH/AODA Redesign Initiative will continue in two of the four pilot sites that are working towards managed care systems – Dane and La Crosse counties. Dane and La Crosse counties will receive funds for the continued support and development of their consumer-run organization and consumer affairs positions respectively. Funding will also be provided to a vendor that will develop and refine a consumer based data driven QA/QI plan for community programs. The vendor will continue the integration, analysis, and reporting of data from instruments developed in the previous five years of the Redesign initiative. The MH/AODA Functional Screen and the ROSA instruments will be a part of this continuing work. The new CCS benefit will be incorporated into the Redesign initiative as a core service that promotes consumer focused recovery based services and supports. Finally, trauma training for consumers will continue to be developed and offered to consumers in areas of the state.

$275,945 Systems Change

The Systems Change funds will focus heavily on expanding consumer involvement and implementing Recovery principles. Funds will be used to support consumer and peer support agencies to make advocacy and self-advocacy services available for CCS, children's programs, CST children's programs, and the elderly. The remainder of the funding will be allocated to counties for the development of CCS paid peer support specialists, the development of quality improvement systems, and strategic planning to increase consumer empowerment and advocacy in participating in developing their own care plans. Finally, Racine and Waukesha counties will continue to be funded for implementing innovative practices to provide mainstream mental health services for persons who are homeless with SMI.

$172,799 Training

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 mental health services and crisis services, and
- consumer/family stipends and expenses to facilitate their participation in statewide mental health planning and policy meetings.

$190,000 Recovery and Prevention/Early Intervention

Activities will include Recovery trainings for providers/administrators, implementation of a Recovery-based approach to service delivery, and information dissemination on Recovery principles. Prevention and early intervention services will include children's suicide prevention, primary care provider training on mental health issues, and infant mental health.

$65,000 Wisconsin Protection and Advocacy

The Wisconsin Coalition for Advocacy is the designated agency within the state to provide protection and advocacy for persons with mental illness.

$300,034 State MH Authority Staff – Planning, Technical Assistance, and Oversight
BMHSAS staff (5.9 FTEs) who work in the mental health field will be funded through the MHBG. Staff plan services, provide technical assistance and guidance to local mental health providers and programs, monitor the implementation of programs, and evaluate mental health programs.

$106,730 Administrative/State Operation Costs
These funds cover accounting, mental health HSRS data collection, and indirect costs of administering the grant. A $3,003 reduction was taken from state operations as part of the $50,306 overall FFY 2005 MHBG reduction. This reduction will be maintained in the FFY 2006 budget.

$6,814,203 TOTAL

FFY 2007 MHBG Budget

$2,513,400 County Formula Allocation
Funds will continue to be used for the eight priority program areas described above in the FFY 2006 budget.

$1,826,500 Children's Initiatives - ISP and CST
Funds will continue to be used to support the development and operation of children's integrated mental health programs across the state with the goal of having integrated programs in every county.

$874,000 Family/Consumer Self-Help and Peer to Peer Support Programs
Wisconsin will maintain its funding commitment to funding consumer self-help and support programs as described above.

$489,795 Mental Health/AODA Redesign Initiative
These funds will continue to be used as specified above.

$275,945 Systems Change
These funds will continue to be used as specified above.

$172,799 Training
These funds will continue to be used as specified above.

$190,000 Recovery and Prevention/Early Intervention
Recovery and prevention/early intervention services will continue to be funded as described above with a special emphasis on implementing Recovery principles into the development of the new CCS benefit.

$65,000 Wisconsin Protection and Advocacy
These funds will continue to be used to support consumer advocacy services statewide.

$300,034 State MH Authority Staff – Planning, Technical Assistance, and Oversight
See FFY 2006 budget above.

$106,730 Administrative/State Operation Costs
See FFY 2006 budget above.

$6,814,203 **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 19
Summary of Plan for FFY 2006 and FFY 2007 Community Mental Health Services Block Grant Funds

Program	Funding	Federal Criterion
County Formula Allocation	$ 2,513,400	I, II, III, IV,V
Integrated Services Projects/wraparound	$ 1,826,500	III
Consumer/Family Self-Help & Peer Support	$ 874,000	I, III, IV,V
MH/AODA Redesign Initiative	$ 489,795	I, II, III, IV,V
Systems Change	$ 275,945	I, II, III, IV,V
Training	$ 172,799	I, II, III, IV,V
Recovery and Prevention/Early Intervention	$ 190,000	I, II, III, IV, V
Protection & Advocacy	$ 65,000	I
State MH Authority Staff-Planning & Technical Assistance & Oversight of Contracts	$ 300,034	I, II, III, IV,V
Administration/State Operations	$ 106,730	I, III,V
Total	**$ 6,814,203**	

Table 20
Wisconsin's Projected County Formula Allocation – CY 2006

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

Price County Human Services Department	8,029
Racine County Human Services Department	100,488
Richland County Community Programs	9,465
Rock County Human Services Department	73,312
Rusk County Health and Human Services Department	9,661
Sauk County Department of Human Services	17,541
Sawyer County Health and Human Services	8,146
Shawano Department of Community Programs	16,604
Sheboygan County Health and Human Service Department	51,197
St Croix County Health and Human Services Department	17,529
Taylor County Human Services Department	9,043
Trempealeau County Unified Board	15,769
Vernon County Department of Human Services	12,392
Walworth County Department of Health and Human Services	22,005
Washburn County Human Services Department	8,386
Washington County - Comprehensive Community Services Agency	37,470
Waukesha County Community Human Services Department	109,469
Waupaca County Department of Human Services	20,786
Waushara County Department of Community Programs	10,433
Winnebago County Department of Community Programs	68,961
Wood County Unified Services	39,193
TOTAL	**$2,513,400**

Table 21

County ISP and CST Projected Allocations for CY 2005

#	County		Amount
1	Ashland	$	80,000
2	Chippewa	$	80,000
3	Dunn	$	80,000
4	Eau Claire	$	80,000
5	Fond du Lac	$	80,000
6	Door	$	80,000
7	Kenosha	$	80,000
8	La Crosse	$	80,000
9	Portage	$	80,000
10	Marinette	$	80,000
11	Marquette	$	80,000
12	Racine	$	80,000
13	Rock	$	80,000
14	Sheboygan	$	80,000
15	Washburn	$	80,000
16	Washington	$	80,000
17	Waukesha	$	80,000
18	Waushara	$	80,000
TOTAL ISP ALLOCATION =		**$**	**1,440,000**

2005 Projected CST Allocation

CST Project Coordination and County Training	$	114,800
10 Current CST Counties	$	405,000
Total CST Allocation =	**$**	**519,800**

2005 Projected ISP & CST Allocation

ISP Allocation	$	1,440,000
CST Allocation	$	519,800
Total ISP & CST Allocation =	**$**	**1,959,800**

Funding Source:

FFY 05 MHBG	**$**	1,826,500
SFY 05 GPR	$	133,300
Total MHBG & GPR	**$**	**1,959,800**

STATE PLAN PERFORMANCE INDICATOR
FFY 2006-2007

Criterion 5

Goal 1:	**Increase the number of counties with children's service staff trained in organizing collaborative service delivery systems within the children's wraparound programs.**
Objective:	Annually increase by two the number of counties with children's service staff trained in organizing collaborative service delivery systems within the wraparound programs for FFY 2006-2007.
Population:	Children with SED and their families.
Criterion:	Management Systems.
Brief Name:	System organization training.
Indicator:	Number of counties with mental health and other children's service agency staff trained in organizing wraparound programs annually in FFY 2006-2007.
Measure:	*Numerator:* Number of counties with mental health and other children's service agency staff trained in organizing wraparound programs in FFY 2006. *Denominator:* Number of counties in Wisconsin in FFY 2006.
Source(s) of Information:	ISP/CST training visit reports
Special Issues and Strategies:	Wisconsin provides initial system organization training for new wraparound programs, but does not track the number of staff trained. In addition, a train-the-trainer model is in effect in which county staff at the initial training provide subsequent training to the rest of their staff. Since it is difficult to track the number of staff trained, the number of counties receiving initial training are used.
Significance:	One of the primary focal points of wraparound programs is the systems change approach used to organize multiple child-serving agencies into a collaborative service system. Because this is a new approach for many children's service agencies, staff training is essential at the beginning of the implementation phase to gain staff buy-in to the process. With its emphasis on the family being a part of all treatment decisions, wraparound programs are in accordance with NFC Goal 2.

STATE PLAN PERFORMANCE INDICATOR DATA TABLE

Fiscal Year: **FFY 2006-2007**

Population: **Children with SED and their families**

Criterion: **Management Systems**

Performance Indicator: System Organization Training	**FFY 2003 Actual**	**FFY 2004 Actual**	**FFY 2005 Projected**	**FFY 2006 Target**	**FFY 2007 Target**
Value:	47%	60%	60%	63%	65%
Numerator:	34	43	43	45	47
Denominator:	72	72	72	72	72

Action Plan

Similar to Criterion 1, achievement of the targets for this performance indicator will be dependent on Wisconsin's ability to increase children's mental health programming.

In FFY 2006, Wisconsin will add two additional CSTs. We will use funding from multiple sources to fund the new CSTs. In addition, we will explore the possibility of providing support in the form of technical assistance and training to additional counties which will allow them to start a CST program in the absence of additional funding from the state. Grant County, which has received this technical assistance but is not receiving funding from the state, is already operating a CST.

In FFY 2007, Wisconsin will add two additional CSTs. The funding agreements for the first CST programs stipulated that the counties would receive funding for a period of three to five years. As the funding period for the original CSTs ends, we will use direct the funds to new counties for implementation of CST programs.

Even in the absence of clearly identified new funding, Wisconsin will continue to provide training and technical assistance to counties that have expressed interest in starting a CST. This will allow those counties to quickly implement the program as funding is made available.