Mental Health
1989-90

11/21/90
ANV Newsletter

MENTAL HEALTH CONCENSUS
DECEMBER 4, 1990

At the November general meeting , members of the Mental Health Study Committee presented an overview of the mental health system in Outagamie County by describing its various components and providing data, anecdotes and concerns collected in interviews conducted over the last few months. The components discussed were the structure of the Department of Human Services which oversees services for the chronically mentally ill, Crisis Intervention, hospitals, the commitment law and the Clinic/Community Support Program.

Crisis Intervention (CI) is a twenty four hour, seven day per week emergency mental health service composed of two separate but integrated services: the crisis phone and the crisis team. On 1989, there was a 13% increase in the number of calls that involved crisis counseling. The number of different callers increased by 9.6%. Also, in 1989, a total of 640 cases were dealt with by the crisis team - an average of 53 new cases per month. In ouir interviews there was a feeling that CI may be one of the best in the state in its response time and quality of work.

Hospitals. Outagamie County contract for services with St. Elizabeth's Hospital, Brown County Mental Health Center and the Fond du Lac Health Care Center. Both Brown County and Fond du Lac are state licensed county run facilities. THere are serious and varies concerns about each of the hospitals, ranging from problems with the acceptance of medical insurance to the systems and methods of treatment.

Commitment Laws. The laws and procedures of commitment were reviewed at the November meeting. Please se the November issue of the FORWARD for more indpeth information. Several problems with this law were uncovered in our interviews:

:Some judges are better thatn others and sometimes decisions are nade which are not practical for the mentally ill person.

:If the commitment process fails, which, we are told, it frequently does because the criteria for placement are rigid and, if the client doesn't voluntarily place himself in an inpatient setting, NOTHING can be done to help him or her.

:The law is designed to protect individual liberty. As a result, there is

some apprehension on the part of doctors and public defenders to declare someone mentally incompetent.

Clinic/Community Support Program provides the community based support care for the chronically mentally ill (cmi). This program is mandated by the state and administered by the County Human Services Department. Its primary goal is to provide services to enable the cmi to function independently in the community with some degree of quality to theot lives. The two elements of this program consist of the Community Support Program (CSP) and an outpatient clinic. The former is a coordinated care and treatment program providing a range of services including rehabilitation, support and ongoing therapy. The latter is a psychotherapy unit with less comprehensive services to clients.

The state has not certified the Outagamie County CSP. The county claims, however, that 96% of the required standards are in place. In fact, it was one of the first CSPs in the state and is considered one of the best programs available; but, the program doesn't currently meet the required staff/client ratio of 18-20 clients per staff member. The program has a ratio of 28-35 clients per staff member. The couinty will lose state funding because of this but the Department of Human Services can't affors to hire new staff and they don't want to create waiting lists. In every other area, they claim to provide services above the state standards.

The most frequent concern expressed in the interviews were the lack of funding and staff in the CSP. It was generally felt, however, that given these constraints, the CSP does the best it can and tries to consumer oriented.

Housing is an area of grave concern to the county administrators, advocacy groups, private practitioners, hospital staff and administrators, and the consumers. Greater stress is being put on the already burdened facilities because of the state mandates for community placement of the cmi. There are waiting lists for group home placements. Operation costs are rising and insurance doen's always pay while United Way finding has also been cut back. Requests for additional facilities have been in the last two county budgets and have been rejected until this year. The new facility will not be complete until late 1991 and it will be filled to capacity almost immediately.

The Concensus Questions for the mental health study are included elsewhere in this newsletter. With the Mental Health Committee, I would urge the membership to attend the Dec. 4 concensus meeting to so that we may eventually play a role in monitoring services for the cmi. (See the calendar for place and time). Please review the mental health articles in the FORWARD from Sept. 1989 to Nov. 1990 for more background material.

As chair of this committee, I would like to commend the outstanding work of this group. In spite of the copious amount of information we gathered, most of us would agree that we have only scratched the surface of the complexities of providing services for the cmi in a timley, cost effective and humane manner.

Gretchen Bambrick

handout for GEN MTG NOV. 1990

The nine specific areas that need to be addressed in the plan are as follows:

1. Establish and implement an organized, community-based system of care for persons with severe mental illness.

2. Specify targets: The numbers of people with severe mental illness, how many will be served, and the areas in which these clients live.

3. Describe services to be provided to enable these individuals to have access to mental health services, including treatment, prevention, and rehabilitation.

4. Describe services to be provided to enable these individuals to function outside of inpatient institutions.

5. Provide for activities to reduce the rate of hospitalization.

6. Require the provision of casemanagement to each individual with severe, disabling mental illness who receives substantial amounts of public funds.

7. Provide a program of outreach for persons who are mentally ill and homeless.

8. Consult with employees of various long-term care facilities.

9. Use mental health planning councils for advice on the development of the plan.

Wisconsin has developed a list of eleven goals for its mental health system. These are as follows:

1. Strengthen the quality and consistency of the county's Community Support Programs by implementing program standards and providing incentives to meet those standards.

2. Develop a comprehensive, community-based system of care and treatment for severely emotionally disturbed children and adolescents.

3. Increase accessibility to and appropriateness of mental health services for Wisconsin's ethnic and racial minority populations.

4. Improve the mental health work force by developing professional human resources for the public sector.

5. Develop administrative rules for specialized longer-term inpatient treatment.

6. Revise and restructure mental health policies and rights under the Wisconsin Medical Assistance program.

7. Develop a performance measurement data system.

8. Improve employment options for persons with severe mental illness.

9. Insure the availability of specialized community-based treatment, rehabilitation, and support services to elderly persons and persons who are hearing impaired, as well as other persons with special needs or dual disabilities.

10. Promote the development of an array of housing options that are normative and affordable, chosen by consumers, and allow consumers to receive treatment and support appropriate to their needs.

11. Promote the development of a system of housing and supports for persons who are homeless and mentally ill.

The most important characteristics of Wisconsin's mental health system are:

1. A fixed point of responsibility for provision and financing of all mental health services at the county level.

2. A low number of state-operated psychiatric hospital beds (565 staffed beds)

3. Protection of patient's rights.

4. Services of the least restrictive quality.

5. A strong commitment of community-based treatment of seriously mentally ill persons of all ages

6. A strong advocacy network, including the Alliance for the Mentally Ill, the Wisconsin Coalition for Advocacy, the Mental Health Association, Family Ties, and several consumer groups.

Although state statute mandates that a continuum of care and services be made available to all persons in the county, the responsibility for targeting, planning, budgeting, and expending funds for services rests with the county. This concept of local control is what makes the Wisconsin service delivery system unique.

Policy Changes Impacting on the Mental Health System

During the past 10 to 15 years, Wisconsin's mental health system has undergone several significant changes brought about by changes in state and federal polices. These changes have impacted greatly on the system. The following list briefly describes these changes and their significance:

1971 *Chapter 51 Mental Health Act became law.* This legislation, implemented in 1974, delegated responsibility for the well-being, treatment and care of mentally ill, developmentally disabled, and alcohol and drug dependent citizens to county government. Chapter 51 now requires counties to provide diagnostic evaluation and assessment services along with outpatient treatment, residential services, day treatment, emergency care, inpatient services, and community support program services.

1972 *Research began at Mendota State Hospital with the Program of Assertive Community Treatment (PACT).* Funded through the National Institute of Mental Health, PACT developed a model of community-based care that improved client community tenure and reduced hospital use for persons with long-term mental illness. The project (empirically) demonstrated model efficacy (Stein, Test, et al., 1980).

1972 *The federal court case, Lessard vs. Schmidt, was heard in Milwaukee.* The decision resulted in major changes in the civil commitment process, including the requirement that treatment be provided in the least restrictive environment and establishing the "dangerousness to self or others" standard. This case was the force behind deinstitutionalization in Wisconsin.

1973 *The Children with Exceptional Needs Bill,* Chapter 89, as amended, Wisconsin Statues Chapter 115, is the Wisconsin version of the federal Education of the Handicapped Act.

1974 *County mental hospitals were converted to nursing homes.* These facilities provided care to the elderly, developmentally disabled, and long-term mentally ill population. As specialty hospitals, these facilities were ineligible for Medical Assistance funding for persons between the ages of 21 and 65. As nursing homes, these same facilities could collect MA dollars for this population.

1974 *State hospitals were converted to State Mental Health Institutes* with new mandates to provide specialized training and consultation services to community mental health boards, develop demonstration projects through research, and establish specialized inpatient units.

1975 *Legislation was passed* (ss.46.23 Wis. Stats.) to allow county boards of supervisors to create county human service boards by combining the community services board with the county social services (welfare) board. Other county-mandated boards could also be included, especially public health and aging. The combination of responsibilities led to the merging of program funding and service delivery.

1977 *Special Allocation for Community Support Programs.* To initially provide state funding for CSP development, existing dollars earmarked for long-term inpatient services were reallocated to community support program development. A total of $876,000 was distributed as seed money to counties through an RFP process. Twenty-three community boards received CSP funding. In 1987, the total CSP funding was $6.7 million. All 60 boards are receiving the funding and are operating an identifiable CSP.

Chapter 48, the Children's Code (ss.48.01 Wis. Stats.) was established "to respond to children's needs for care and treatment through community-based programs and to keep children in their homes whenever possible." Chapter 48 provides judicial procedures and assures fair hearings and protection of children's legal rights.

1979 *The National Alliance for the Mentally Ill* (NAMI) was founded in Madison, Wisconsin. Establishment of the family advocacy movement substantiated to legislators and policy makers the need for improved services.

Community Youth and Family Aids Program (ss.46.26 Wis. Stats.) provides a sum of money distributed by the state to counties to be used for providing services to children who are alleged delinquent, adjudicated delinquent, or alleged or adjudicated to be in need of protection or services according to Chapter 48, the Children's Code.

1980s *Community Aids funding levels were essentially frozen.* While inflation from 1979 through 1989 amounted to 70 percent, the base-level funding to counties increased by only about 20 percent for the same period. Additional mandates placed on counties increased client needs, and new long-term treatment populations have placed an enormous strain on the local capacity to serve those mentally ill persons most in need. The long-term population that counties must now begin to serve under IMD and OBRA will further affect the capacity of this funding source to pay for mental health services.

1982 *The Gatekeeper waiver* request to the Health Care Financing Administration gave county departments of community programs the authority to review Medicaid hospital admission requests and direct the recipient to a particular provider. The waiver was withdrawn by the Health Care Financing Administration in May 1987.

1984 *Legislation mandating CSP.* Initiated by the CSP Advisory Committee, legislation was enacted mandating the establishment of Community Support Programs. CSP services would be available in every county in Wisconsin, along with inpatient, outpatient, and day treatment services.

1985 *Family Support Program* (ss.46.985 Wis. Stats.) is a state-funded program assisting eligible families to keep a severely emotionally disturbed child at home. Twenty-three counties participate, providing funds for goods and services unavailable through other programs.

1987 *Wisconsin Family Ties,* a statewide network of local support of parents of emotionally and behaviorally disturbed children and adolescents was established.

1988 *The federal government instituted major changes in long-term care for the mentally ill.* Aimed primarily at nursing homes and their patients with mental illness, federal IMD and OBRA policies prescribe which facilities may care for patients with mental illness. These policies are forcing states to evaluate facilities, relocate patients, and replace millions of federal dollars with state and local funds. Since Wisconsin has converted many of its county mental hospitals to nursing homes and collects MA dollars for many people with mental illness, this new regulation impacts greatly on the state.

1989 *Development of CSP Program standards.* CSP Standards will help ensure program quality. The lack of uniformity in quality and the low priority the CSPs receive in some local systems have necessitated the development of standards. The CSP Standards draw on fifteen years of ongoing research at PACT and ten years of clinical experience gained from community support programs throughout Wisconsin. For community-based treatment to work, CSPs require sufficient numbers of certified staff, accurate assessment of clients, and monitoring of client outcomes and program effectiveness. The CSP Standards define staff qualifications, the number of staff required, and client assessment and treatment goals to ensure quality and accountability

AGING AND LONG-TERM SUPPORT DIVISION

Manager (ASP 5)

AGING SERVICES UNIT

Supervisor (ASP 8)

Nutrition Program Coordinator (ASP 10)

Dietician (Contract)

Site Managers (11) (P.T.)

Week-end Hostess (2) (P.T.)

Food Transporters (8) (P.T.)

Benefit Specialist/ Outreach (ASP 15)

Senior Energy Aide/ Outreach (50%) (AAA Placement)

Home Handyman (3)

ADULT SERVICES UNIT

Supervisor (ASP 7)

General & Protective & Long-Term Support Programs

Social Worker V

Social Worker V

Social Worker V

Social Worker IV

Social Worker III

Social Worker II

Unit Support

Human Services Specialist I

CLINIC/COMMUNITY SUPPORT UNIT

Supervisor (ASP 7)

Clinical Therapist (ASP 7)

Clinical Therapist (ASP 7)

Psychiatric Registered Nurse (ASP 9)

Psychiatric Registered Nurse (ASP 9)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

DEVELOPMENTAL DISABILITIES UNIT

Supervisor (ASP 7)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

Community Support Specialist (ASP 9)

VPI CONTRACT

Community Support Specialist

Community Support Specialist

Community Support Specialist

Community Support Specialist

SUPPORTIVE HOME CARE UNIT

Supervisor (ASP 11)

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

Homemaker Aide

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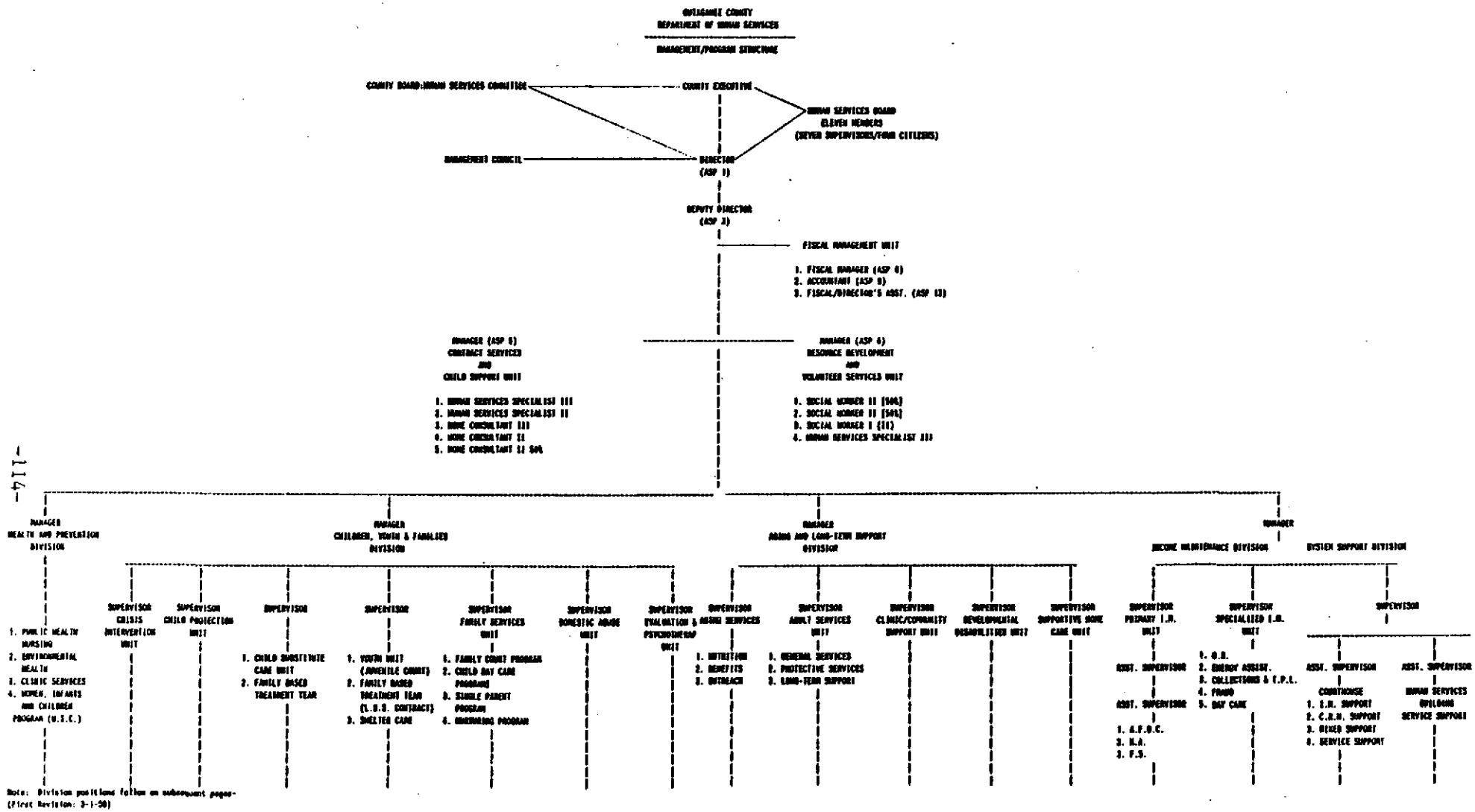

Note: Division positions follow on subsequent pages-
(First Revision: 3-1-90)

ISSUES FACING THE MENTAL HEALTH SYSTEM

1. The system has a shortage of specialized services and support options critical to community-based care.
2. There is a need for employment opportunities.
3. There is a need for accessible and affordable housing.
4. Counties need access to specialized resources for assessment and treatment for persons with long-term and persistent symptomatology.
5. The number of psychiatrists available and willing to work in the community mental health system is extremely low.
6. Other mental health professionals who are trained and experienced in severe mental illness are also in short supply.
7. The need for education and training programs is urgent.
8. Increases in state and federal funding have not kept pace with inflation, at the same time, county responsibilities have increased.
9. Rates under the Medical Assistance program are significantly below costs and are less than rates in border states.
10. One or two clients in a county who require extensive inpatient care can deplete a large percentage of a county's budget.
11. Mental Health issues need to be put on public, legislative, and executive agendas.

* Ask state for permission to publish anything?

MENTAL HEALTH STUDY - REPORT TO THE BOARD - JA15, 1991.

1. Concensus.

2. Future of Committee - Public relations

A. Can't publish anything concrete until the state comes out with its positions and/or publications in case their findings contradict ours.

B. Press release to newspaper - bland - stress positive aspects of findings.

C. Go to newspaper - to Mike Walter (with Jan Quinlan) to write an editorial - suggest they write a 6 part series - i.e.mentally you see, MI you don't see, MI in institutions, the law, the families, employment for the MI, funding, etc. - give them a blue book list of people to talk to for their articles.

D. TV show on cablevision - Dorothy Johnson talking to Bob Rousseau, AMI, Sherm Freimak, Barb Grant, or Marsha ? on city council (consumer) or John Rankin show.

E. Do something for National Mental Health Week - when?

F. AMI - Dr. Tory coming to talk to AMI June 1st. Get onto their agenda to talk about out study <u>if</u> state has completed thier concensus and publications. Invite Mona Steele or Paula Anderson to speak.

* 3. Recommendation of committee to have a Social Policy person on board - target specific topics to monitor - MI, Juvenile Justice (jailing truants) and overcrowding jails.

G. When is state convention - tie convention in with AMI??? 1st wk in May

H. Sept. - Outagamie County is hosting the convention of counties - is there something we could tie into? A booth, info about our study, something with AMI? Eye catching flyers.

3. Recommend that the state adopt a MI study of children/adolescents. Paula supports.

Distribute copies of our report for those interested.

* Make this directions to the board at annual mtg.

~~12. C. of [illegible]~~

~~copies of~~ Report. -

1. C. to Jay Povaluy Blaney Mieftee
2. ~~Send to Madison~~
3. Charges to Sue Sultan
4. ~~Call Paula~~
5. Thank you letters

Question #8 .

Should federal funding focus on institutional care or on community based care? Explain.

Answer .

Federal funding should be allocated to areas of need. If funding is too heavy on institutional care, then too many people are "locked up" inappropriately; if funding is too heavy on community based programs, then too many patients are forced out of institutions inappropriately.

Newsletter

The Mental Health Committee began its study in the fall by viewing a film which provided an overview of how mental health has been treated historically in this country from the the last century to the present. Sally Mielke, committee member and Chair of the Outagamie County Human Services Board, provided the study group with an understanding of the county structures and governmental services as they pertain to providing funding and support the mentally ill in our area. Darci Vickman, another committee menber and professional in the field of mentla health, provided the committee with inforamion on the private sector services.

The state League has provided us with an outline for a county study to be conducted. The committee has selected key individuals in the county government administration and service providers as well as in the private sector service providers to interview for the study; it has also drafted a letter to these people requesting their cooperation in the study. The committee intends to complete the survey over the summer.

The two units for mental health were held on April 3rd and 4th. Both units focused on providing background information on national, state and local funding for mental health services, Outagamie County services as well as funding issues and available services in the private sector.

Mental Health Unit

April 4, 1990

Attendance: Deb Matz, Bev Wieckert, Anna Faye Dodd, Sally Mietke, Joy Povolny, Jan Quinlan, Darci Vickman, Helen Nagler.

Jan define scope of the mental health study to the group. Also defined chronic mental illness vs "organic illness."

State and federal dollars are constant, however these governing bodies have increased the mandated programs.

$48.2 bil. spent in 1983 on scitzo.
spent $15/patient mental illness research vs. $170 spent per patient on cancer research.

Wisc. ranked 1 or 2 in delivery of services to the mentally ill.
CSP- Community Support Programs (Chapt. 51) Was defined; eligibility also defined.
We spent alot of time talking about the structure of county government. As a group we under little of its working. Talked about the Advisory board established by state law (4 citizens, 7 county bd. members) Authority is in the committee which is part of the County bd. Felt communication need to be better coordinated. Mental Health - huge budget.
Funding: from the state and federal govt, the county and private entities. Acute care at Mendota (Madison), Brown County, Fond du Lac County, Winnebago (Oshkosh) Reimbursements dont cover approximately 80% of the costs.
Handling of patients: county contracts with the above facilites (some). St. Elizabeth's is also used.
In-patient, without insurance will be sent back to the county if they go directly to an institution (private).
Out-patients can be helped at private institution with some assistance sought by the private institution.
Both programs try to have patients pay what they can to help cover the costs.

Outagamie will use the closest institution and the least expensive for care of a patient.

Fox Valley Hsopital - dual treatment (depression - substance abuse) They are "heavy" of therapy.

Chronic Care-
Outagamie County Health Center - patients in there since 1974
Federal mandate more from institution to residential units (patient, that is)
Our county group home house 6-8 people, Lutheran Social Services also provides services to the county's mentally ill.
The more chronic the more expensive the care.
Federal govt. has backed-off somewhat on their demands to relocate individuals in residential settings.

Group home care costs the county about $350,000/yr. Half may be recovered by government sources, other than the county. This figure doesn't include medical care expenses.

Residential setting are more expensive, but provide a much better quality of life.
Many mentally ill are living at home with their parents.

Vocational training at Valley Packaging. Two people for one job, until patient can handle the responsibility on their own.

People in homes grouped by function. Group homes are considered CSPs.
Some patients reside in appartments. Outagamie has 10 such people in the past 3 years.
"locked wards" acute - might be organic brain damage

Definition of program funding given

Community aids funding - state has made legislation stating 50% of the hospitals must have 100% of their costs covered. It was noted that Milwaukee facilities were receiving over 100% of their costs.

County board reluctant to take funds from the state or federal govt. due to fears of discontinued funding in the future, while they have to increase staffing; fears of undue restrictions of funds, also.

Over-match funds - govt. says there has to be the program and only provides a fraction of the funds to run the program.

Gretchen -
Hope you can read and understand these notes.
We spent a lot of time trying to figure out the different levels of government involved, as well as the structure of the county government. Can this study be conducted without good understanding of the way the county works? If not, we need to put something together about county govt. (I have talked to Helen and Sally about doing this in the fall.)
Have a Happy Easter.

Deb Matz

Apr 1989 LWWI MTG

Wisconsin State Plan for persons ≥ Mental Illness dept HSS 1990-1992 * Comm. based care Sent to Govnr

DEFINITION OF MENTAL ILLNESS FOR THIS STUDY

A mental disorder that requires care and treatment for her or his own welfare or for the welfare of others. For purposes of involuntary commitment, "mental illness" means a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary damands of life, but does not include organic mental disorder or a primary diagnosis of mental retardation, or of alcohol or drug dependence.

CHRONIC MENTAL ILLNESS

"Chronic Mental Illness" means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. Chronic mental illness includes schizophrenia as well as a wide spectrum of psychotic and severely disabling psychiatric diagnostic catagories, but does not include organic mental disorders or a primary diagnosis of mental retardation or of alcohol or drug dependence.

SCOPE OF LWWI STUDY

Coordination and Funding of Services for the Mentally Ill.

FOCUS :Programs that directly affect the kind of services available to people with mental illness.

SCOPE :Examine the coordination of mental health programs and explore treatment services with the aim of assuring that at least the minimal humanitarian services are extended to people with mental illness. Examine issues of community safety and the safety of the individual who is mentally ill.

Address and understand the financing of programs that effect people with mental illness with special note of those with chronic mental illness.

Consider the role of each level of government and the private sector in providing funding.

Mental illness with the major depressive orders and schzophrenia is within the scope of the League study. The study, however, does not include "developmental disabilities" or "organic mental disorders" such as cerebral palsy, epilepsy, autism, mental retardation chemical dependency, Alzheimer's or senility. These people may be mentally ill with a dual

diagnosis.

FACTS ABOUT MENTAL ILLNESS

1. One in 100 people will develop schizophrenia sometime in their lifetime (143,000 every year in the U.S.)
2. In 1983, $48.2 billion was spent on costs incurred by schizophrenia.
3. Causes of mental illness are not known for sure. The three components considered in the medical model are: a genetic factor; a sociological factor; and and environmental "stress" factor
4. A mentally ill person is not more or less likely to commit a violent crime than a normal person.
4. Serious mental illness is the nation's leading medical problem, affecting one in four families in the U.S.; but funding per patient for research has not matched the prevalence of the problem. ($15 for mental illness; $170 per patient for cancer research)

CHAPTER 51

WI's mental health system is governed by Chapter 51 of the Wisconsin statutes, the Mental Health Law .Under this law the counties must provide a full range of services. The state legislature appropriates money to the counties based on a formula also specified in the statute. This appropriation is called Community Aids .(More about funding later).

Chronological Development of Chapter 51 and Community Support Programs .

1974 . WI's mental health legislation enacted. It mandated a community-based system of mental health to be accessible to all citizens with severe mental illness.

Problems: Because the current state posture is cost containment, there are battles for limited resources, institutional facilities or expanded community-based care.

:Federal mental health policy, with some of the most significant changes in decades, is increasing local responsibilities with limited additional funding.

1977 .A special allocation was made available for Community Support Programs .(CSPs)

1984 .Legislation was enacted to mandate CSPs.

1988 .CSP Program Standards were developed to ensure program quality and uniformity.

COMMUNITY SUPPORT PROGRAMS

As mandated by Chapter 51, a CSP is:

"CSP means a coordinated care and treatment program which provides a range of treatment, rehabilitation and support services through an identified treatment ptogram and staff to ensure on-going therapeutic involvement, individualized treatment, rehabilitation, and support services in the community for persons with chronic mental illness"

Support services include:

1. Medical
2. Financial
3. Housing
4. Vocational
5. Counseling
6. Daily living skills
7. Socialization/Recreation activities

Eligibility . Eligibility requirements include persons over 18 years of age whose psychiatric illness is severe and persistent to a degree that requires long-term treatment of continuity of care to maintain stable adjustment.

Diagnoses are usually schizophrenic or an affective disorder but may include other psychotic or delusional disorders.

Clients cannot have a primary diagnosis of drug or alcohol abuse or mental retardation; however, a secondary diagnosis is acceptable.

FUNDING

Progeams serving the mentally ill in WI are funded predominately by public dollars. The federal, state and county governments share the financial responsibility. Major funding sources are:

:Community Aids
:Supplemental Security Income (SSI)
:Social Security Disability Insurance (SSDI)
:Medical Assistance
:Community Options Programs
:Block Grants

Community Aids . State and federal funds distributed to counties for human services. Basic formula for allocation of funds is determined by what the county received last year and increases authorized by the state legislature for the present year. THe reported expenditures by counties in primary community aid for mental health services in 1988 was $102,276,918, serving an estimated 77, 229 persons. ($ amount includes Community Option funds and Block Grants)

SSI,SSDI, SSI-E

A person financially needy and mentally ill is eligible for Supplemental Security Income . SSI is funded with income taxes.

If a person under 65 is unable to work because of a mental disorder but has worked earning credits and has paid social security taxes, she or he is eligible for Social Security Disability Insurance .This federal program is funded through F.I.C.A.(Federal Insurance Compensation Act)

The national average for approved allowances of disability applications for mental disorders is 20%. In 1985 in WI it was 34.1%.

An SSI average monthly payment check for an eligible individual living independently in 1989 is $368 from federal funds plus $102.72 from WI medical assistance funds In order to recive SSI-E (Exceptional Expense Supplement),a fund for the chronically mentally ill,the county must initiate and certify the application; if approved, the state pays the recipient an additiojnal $203.16.

The federal portion of the basic SSI will be $386 a month in 1990. Other income from wages earned will reduce the payment received. However, in WI, as long as the recipient recives $1 a month in SSI s/he may continue to use the medical assistance card In 1989, WI ruled that an income up to $16,179.28 a year still entitles a needy recipient to continue with medical assistance.

In 1988, WI SSI paid $14,900,000 a month for disabled an average of $229.40 per recipient.

Medical Assistance .To determine a figure for the Amount WI spent in medical assistance, the following categories of expenditure were included:

:IMDs (institutes for mental disease) for persons under 21 and over 65

:Psychotherapy

:In-patient and out-patient care at mental health clinics, specialty hospitals and nursing homes.

With all designated categories available in th earea of mental health, the amount spent by the stste in the fiscal year 1988 was $91,728,496. The categories do not include IMDs for 22-64 year olds and coverage through insurance health maintenance organizations (HMOs). Children aged 21 and under account for 60% of all in-patient services for mental health and alcohol and other drug abuse under medical assistance.

Of special interest to our study regarding medical assistance, Community Support Program standards (HSS 63) thast went into effect May

1989, will be reimbursable with federal dollars on Jan 1, 1990 provided programs meet the standards and become certified.

Block Grants .Block grants are made usually to states or local communities for broad purposes as authorized by legislation. Block grant monies in WI used in the field of Mental illness totaled $1,072,896 in 1988 .

REPORT

OF THE

MENTAL HEALTH STUDY COMMITTEE

LEAGUE OF WOMEN VOTERS

OF APPLETON

December 1990

Introduction

The population of Outagamie County is estimated at 141,376 as of October 1990. The number of people currently being reached by the Department of Human Services Mental Health programs is: approximately 200 in the Community Support Program (CSP) which is a case managed coordinated care and treatment program providing a range of treatments and services; 100 in the Clinic Program which is less comprehensive than the CSP providing outpatient care of therapy and medications; and, 300-400 people who are not currently active but may need intermittent help.

The mental health study committee devised a list of key people in the Outagamie County support system for the mentally ill (See Appendix A for the list of committee members and interviewers and Appendix B for the list of people interviewed). The list was divided among committee members and the interviews were conducted over the summer and into the fall. Some interviewers felt that the questions in the County Study form were inappropriate if the person being interviewed was not tied directly to the system yet was a services provider in some capacity. They, therefore, asked their own set of questions which were more relevant (See Appendix C for an example of such questions). The information in this report is pulled from these interviews.

Adequacies and Inadequacies of the System

The committee does not feel it can state emphatically that the services provided by the county are adequate or not, but it identified some positive and negative aspects of the system. The committee members are concerned about people who may be falling through the cracks of the system regardless of how hard a department or program tries to prevent it. Throughout the interviews, the Department of Human Services (DHS) was generally regarded as being consumer oriented, caring, compassionate and doing as much as they can given their fiscal and staff constraints.

One program which appears to be working well for ~~the~~ some mentally ill is the opportunity to work for Valley Packaging Industries (VPI). VPI contracts with the county and employs DD and CMI in three different programs. Each program addresses a different level of functioning ability of the workers. The pre-vocational program tends to employ people with a primary diagnosis of DD and who are very low functioning. Employees can graduate from the pre-vocational program into the vocational setting. In this program about 30% of the employees have a primary diagnosis of CMI, 60% DD, 10% physically disadvantaged. The program involves about 750 people; 115 of

these are staff, 40 of whom are also program participants. While most are from Outagamie County, some are from Calumet County.

The operation is run as a business, not as a human service agency. The philosophy behind this is that it gives the employees a sense of pride in their work, that this is not a charitable handout. VPI is not a vocational school to teach skills; their mission is to teach people about work behavior, attitudes and responsibilities. If the employee comes into the program with a skill, VPI will attempt to match the person with an appropriate job to use his/her skill. Regular evaluation of the employees are conducted to find the right job for each person.

Workers are paid by the hour based on productivity. Each employee has an individual program. There are 35 cases per case manager. Up until recently, 17% of VPI's total budget came from the DHS but now DHS is providing about 30% of the budget because of an increase in the numbers of lower functioning people, mostly DD.

The third part of the program involves placing people in work situations in the community. A case worker remains on site to help train the employee. The community has apparently been quite cooperative. Jobs are found in fast food establishments, clerical and janitorial services. The employees are paid at least minimum wage. Presently there are approximately 15 people in this program.

At this time there is no waiting list to get people into the VPI programs. One criticism of VPI though, was that they do not teach trade skills but VPI does not see this as part of its mission. Vocational training is offered through the Goodwill services.

Another employment program of VPI is Custo Cleaning, a commercial and residential cleaning and janitorial service. This business employs approximately 35 mentally ill at minimum wage or better. There are some fairly low functioning people in this program.

A third program sponsored by VPI is the Commun ity Outreach Center, a social and recreational center for the CMI. It is designed to get them out of their homes and to mingle with others. They go on museum tours, ball games, etc and they plan many of their own activities. Some arm chair counselling is provided. Approximately 50 people use it per day. The county pays half and VPI pays the balance to support the Center. Every year at budget time, the question of closing the Center looms up; this year the county would like to see it open seven days a week (it is currently open five days a week). Although no statistics are available, many feel the Center saves the county money in the longer run because they can identify people

earlier who are in need of help and the socializing is therapeutic.

The Crisis Intervention (CI) system was considered by many to be extremely good. The hotline is available 24 hours a day 365 days a year. The paraprofessional answering the telephones appear to be well trained, many have college degrees and some work in health related professions. Face-to-face consultation is also available for any caller if this is deemed necessary by the telephone answerers.

Apparently this CI is unique in this area in that it provides both 24 hour phone service and face-to-face contact when necessary. Calumet County runs an answering service but contracts with Outagamie County for CI for after hours and on week ends. Waupaca County has no emergency crisis phones; all mental health emergencies are referred to the hospital emergency room if the client is able to get there. Winnebago County has a crisis line but no face-to-face consultation.

Dovetailing with the crisis phone workers is the crisis team, composed of three social workers, one of whom is the crisis phone coordinator. The team provides face-to-face contact with the clients when needed. The county considers its CI to be one of the best in WI. The crisis team apparently has a 15 minute response time for one of its team members to go out on a call. According to one county administrator, there are only three other counties with this level of service..

CI is primarily funded by the county, with a small amount coming from the state or third party payment. The state requires that there be a charge for all face-to-face services rendered by CI but not for phone consultation. If the client without Medicare, Medical Assistance or private insurance, CI will charge on a sliding fee scale. If the client can't pay at all, s/he will recieve a fee waiver. CI will also charge the cost of medications on a sliding fee base. CI can authorize hospitalization if the client has no insurance; otherwise hospitals won't accept an uninsured patient.

In 1989 there was an increase in the number of calls that entailed crisis counseling and the number of different callers increased by 9.6%. In 1989 a total of 640 cases were dealt with by the crisis team, an average of 53 new cases per month. For the same year, a total of 83 emergency detentions were initiated, about the same as 1988. Of the 83 detentions, 41 were dropped, 6 were lost at the probable cause hearing, 12 became voluntary clients and 25 were commited.

Clients are hospitalized in one of three facilities: at St. Elizabeth's Hospital, Brown County Mental Health Center or the Fond du Lac Health Care Center. In 1989, a total of 131 were hospitalized, an increase of 17 over

1988. In addition, the total client days were 2212, up from 1988.

Another successful program is run by Goodwill Industries who provide vocational evaluation, work adjustment training, work services, school-to-work program for people who encounter barriers to employment in the workforce, which includes the CMI. The county contracts with Goodwill and refers clients to them. Each client is evaluated and matched with appropriate work. Each client is assigned to one of four counsellors who oversee the case management. The case management team for each client consists of a case manager from Goodwill, the county, residence and a psychiatrist. The client works at Goodwill Monday through Friday, 8:00 a.m. to 3:00 p.m. There seems to be a good rapport and frequent communication among the county, Goodwill and the residential case managers. People interviewed at Goodwill felt that Outagamie County runs a good program and indicated that it provides more services than are mandated by law.

Inadequacies in the system showed up in shortages of staff, housing and funding. Certainly, the first two are a result of the latter.The Department of Human Services (DHS) administrators feel that in comparison to many other counties Outagamie County has a cadillac program serving the needs of the MI. At the same time, however, they are sorely aware of needed inprovements. One area for improvement is staffing. The executive director of DHS will not permit more hiring in spite of the fact that caseloads are very high causing a higher than desired staff turnover due to burnout. The administrators feel they have set a high standard for staff requirements and consequently the pool ofqualified appplicants is smaller. They also feel that better benefits and salaries need to be offered to attract more well qualified people.

There were several repercussions of the staff shortage and turnover identified in the interviews. For many sufferers of CMI, it takes a long time to develop a trust or bond with a counselor or case manager so that when a counsellor leaves, the client feels abandoned , possibly causing a regression before that trust can be rebuilt with a new counselor.

Another concern heard was that the case managers are not getting out in to the field often enough to see their clients in their daily setting. Group home workers and family members of the clients felt this was important. DHS has responded by increasing the mileage for 1991 and has targeted 60% of the case workers' time to be spent in the field but they may not have the staff to carry it out.

One county administrator pointed out that one out of a hundred people suffer from schizophrenia and six out of a hundred are bipolar. Neither the

resources nor the staff are available to monitor these clients daily. Much of the work done by the county program is crisis management rather than prevention work. Their philosophy is to keep the client functioning to the best of his/her ability. If there were more staff, much more prevention work could be done which, in turn, would reduce the number of clients who reach the crisis stage before getting attention. Add to this fact that more CMI people move into counties that provide good services. People are moving from Calumet and Shawano counties to get Outagamie County services so additional pressures are being put on the staff.

Another problem revealed in the interviews was housing for the CMI. There are five halfway houses, one 1/4-1/2 house and several progressive apartments, all of which are contracted services with the county. Up until recently the housing needs have been primarily for men but now the demand for men and women is equalizing. There has been a waiting list for housing for the last few years. For the last two or three budgets, DHS has requested and been denied additional housing. As of September 1990 two people were being housed out of the county and six clients waiting for housing. Calumet County also contracts with Outagamie County for housing their CMI which may contribute to the waiting lists. Two new facilities have now been approved for 1991. One will be a group home for six, the other will be progressive apartments for 6-8. Both will be coed to give DHS the flexibility to address gender needs. DHS does not feel that these two new facilities will eliminate waiting lists entirely but will certainly reduce it and allow DHS to shift clients around to more appropriate housing to suit their individual situations.

Underlying both the staff and housing shortage is funding. In spite of funding shortages, though, within DHS, the community and in contracted services, interviewees said that the present county executive has been very supportive of DHS and this has been reflected consistently in his budgets. Ten to fifteen percent of the total budget has been allocated to Human Services. This is considered to be quite high compared to other counties. Sadly, the county executive is about to retire, and neither of the two prospective candidates is viewed as being sympathetic to human services concerns. In addition, the executive director of DHS is not especially sympathetic to CMI issues. Thus, whatever the funding woes Outagamie County has now, the feeling is they may be worse in the near future.

Homeless

Several years ago DHS applied for and received funds from the Steward B. McKinney - Homeless Assistance Act Mental Health Block Grant. Under this grant DHS hired a case worker to go out into the community and make contact with the homeless and direct them to needed services. The program is overseen by DHS but administered by VPI and the case worker's office is in the Community Outreach Center. The Center is located close to the Salvation Army where many of the homeless go for meals so the case worker has lunch there several times a week and mingles with the homeless on a personal level.

Facts About the Homeless in Outagamie County

1. From January to May 1990, 117 people were served. This includes several contacts for the same people.
2. Twenty one families were served.
3. 73 males and 44 females were seen.
4. 29 were under 18 years old; 20 were between 18 and 21; 30 were between 22 and 35; 35 were between 36 and 59 and 3 were older thatn 60.
5. 112 were white; 2 were Hispanic; 3 Asian; 0 black or Native American.
6. Diagnoses included 16 CMI only; 7 with CMI and substance abuse/dependence; 15 with CMI and DD; 15 were high risk for MI; and 44 other which did not involve MI.
7. Services provided directly or through referral are: crisis services, mental health care, case management, AODA, shelter, transitional housing, permanent housing, food/clothing, medical, financial assistance, education/vocational services, V.A., transportation, advocacy, legal and employment.

The number of homeless in Outagamie County is increasing due to increased awareness of the problem according to one DHS administrator and also due to the tendency for the homeless to gravitiate to communities where the services for them are considered to be good.

Housing

There are five halfway houses, one 1/4-1/2 house and several progressive apartments for the CMI. The housing inadequacies and proposed solutions were addressed earlier in this report (See "Inadequacies"). One observation made by a residential director, however, was that there should

be more levels of structure available in the housing. Currently there are three levels: institutional care, halfway house,and independent living with minimal support provided. The interviewee felt there should be a couple more levels to better serve the client needs and abilities. He proposed that there should be a 1/4-way house which would be a highly structured environment for people newly released from the hospital or IMD who can't handle the freedom and responsibilities of the half-way house. There would be a higher staff/client ratio in this environment.

Another advantage of a 1/4-way house would be that those clients who don't cooperate in the half-way house could be moved to the 1/4-way house until they demonstrate readiness to return to the half-way house setting. Now, if a client is having trouble at the half-way house, s/he is sent back to the hospital where there are no demands or reponsibilities which tends to undermine the behavior modification program.

He also suggested.that there be 3/4 houses which could be a structured apartment setting with two people in one apartment. A twenty four hour staff would assist them when needed with shopping, cooking, budgeting, etc.

The most independent level now are the progressive apartments. For the most part they live as independent adults, handling their own money, cooking, jobs, etc. There is a manager who is in contact with each resident at least once a week. There is a need for more housing of this type.

Also, there is a need for homes for clients who are both AODA and CMI as they are harder to intermingle with people who are just CMI. Another need is for crisis care units for teenagers.

While there are six group homes and several apartments for CMI, there is a total of 22 group homes in Appleton for people with various handicaps or problems.

Commitment Laws.

Many people who were interviewed raised concerns with the existing laws:

1. Some judges are better than others and they make decisions that are not practical for the CMI person.
2. If the commitment process fails, which it frequently does because criteria for placement are extremely rigid, and if the client doesn't voluntarily place himself/herself in an inpatient setting, NOTHING can be done for him.
3. The present law allows the CMI person to refuse medication. It can be court mandated, however, but it takes time to get a hearing. They often don't understand that the medication will help them and they can't

cognitively grasp why they need it.
4. Family and staff realize he needs help but can't do anything until s/he hits rock bottom and becomes dangerous to herself/himself or others.
5. The current law does not permit quick intervention and turn around.
6. Chapter 51 gives people too many rights to the point where they can't /don't get the care they need.
7. Apprehension on the part of doctors and public defenders to declare someone mentally incompetent. The System is designed to protect individual liberty.

Several interviewees were in favor of the fifth standard. One felt that someone should be commited if the county could prove his judgment was so impaired that s/he could not live on his/her own. Another suggested that a compulsory evaluation be conducted during the 72 hour detention.

Two people had no problem with the law. One felt we should err on the side of human rights. Another said that 80% of the involuntary commitments turn into voluntary commitments anyway. There was not total agreement on the commitment laws among the county administrators.

The law enforcement officers expressed some frustration with the way the laws worked because people they deem as "dangerous" to themselves or others and appropriate candidates for commitment are often released by the Crisis Intervention workers whose interpretation may be less rigid.

Waiting Lists.

Waiting lists have been addressed to some extent in other areas of the report (see "Inadequacies"). In housing there are approximately 6-8 people who are waiting for appropriate housing. They are placed elsewhere in the interim.

In the evaluation and psychotherapy unit of the Aging and Longterm Support where most of the services for the CMI are administered in DHS, there is an average 4 week waiting list, sometimes as high as 9 weeks. They do try to refer the client to other services in the interim. The problem is that most places won't accept MA and HMOs won't cover any medical services not provided by their own providers.

CSP Certification.

At the time we interviewed the DHS administrators in September, we were told that the CSP was not certified and that Outagamie County was not going to attempt to be certified. They are in compliance with 96% of the

standards but they don't meet the required staff to client ratio of 1 full time staff to 18-20 clients; they have 1 full time staff to 28-35 clients. Unless the revenue reimbursement is higher they can't afford to hire more staff and they don't want to worsen their waiting lists.

In speaking to a DHS administrator last week (Dec.4), however, I was advised that a complete evaluation of the program has been undertaken and assessments of the clients and they are going to revamp the program into three components. At the moment there are two main components to the CMI program: the Clinic, which has about 100 clients and the CSP which has about 200 clients. For more indepth description of the programs, see the document titled Topic: Outagamie County Mental Health Services. The new configuration would have Clinic and Case management with about 100-200 clients and about 50 clients in the CSP. They feel that under this new arrangement they will probably bring in a minimum of $70,000 in funding for coming into compliance and being certified. The most difficult clients will be in the CSP and the staff ratio will be one staff per 10 clients. They feel that they will be able to address a wider range of needs and severity of illness.

They compared Outagamie County to Dane County's situation. Dane County has similar numbers and types of cases and they have decided to put all of their clients into the CSP which will bring them about $300,000 in additional funding. They apparently intend to add considerable staff with this money.

When asked what DHS will do with the additional $70,000, they responded that it will be used to offset the 1991 tax levy and many of the counseling services will probably be contracted out rather than hire more staff since the executive director of DHS has not altered his restrictions on hiring more staff.

Most of the requested information on page 3-4 of the County Study will be found in the report Topic: Outagamie County Mental Health Services so I will not repeat it here. One area which we have very little information is children and adolescents. We were told repeatedly by both county and community interviewees that while Wisconsin, in general, and Outagamie County, in particular, may have one of the best programs for adults, services for youth are almost non-existent. The committee felt that we had so much information to wade through for the adult program that there was not enough time nor energy to address this problem at this time. They felt that services for adolescents were in such dire straits that this should be considered a separate study in the future.

Jails.

A few times a year the personnel at the jail encounter someone with mental problems but most of their contact comes through transporting people for the Appleton Police Department to Winnebago, Brown County or Fond du Lac. They use off-duty officers from the sheriff's officers for transporting the MI from facility to facility.

There is no formal monitoring system for people incarcerated in the jail who may be suffering from MI. They rely on other inmates to report "odd" behavior or listen for "odd" sounds on their PA system which goes into the cells.

Every certified officer receives several hours of training in the legal aspects of CMI (51:15 and 51:20). The state also mandates that every officer gets 40 hours of in-service training per year in both the legal and psychological aspects of dealing with the CMI. The departmental philosophy is to try to go gently and calm people down.

Calumet County.

Part of the city of Appleton is in Calumet County. Calumet County contracts with Outagamie County for services such as housing and crisis intervention. For more detail and statistics, see the interview reports from "Calumet County Department Head".

Funding.

The budgets for 1990 will be found in the document Topic: Outagamie County Mental Health Services. The proposed budget for 1991 also accompanies this report. It should be noted, however, that in 1990 the Department of Social Services merged with the Department of Human Services to form one large department (DHS). In addition, the formula for distributing the funds among the units within the department has been changed. It will, therefore, be difficult, if not impossible, to compare the budgets from one year to the next. Also, last year Outagamie County received 84% of its Basic County Allocation. This year it received an additional $1.2 million to bring it up to 100% equity. This money will be used to offset costs of existing service and not to increase service levels.

Conclusion.

After assembling the information, the committee has concerns regarding the CMI primarily in the areas mentioned by our interviewers i.e.: housing, staffing and funding. In addition, the upcoming change in the county

executive possibly resulting in decreased funding for DHS is disconcerting. We heard repeatedly from the interviewees how pleased they were that the League was undertaking this study. They were also pleased with the prospect that the League could become an advocate for the CMI - something so desperately needed in their view. Many stated that they are just too overworked and understaffed to provide adequate advocacy for and education about the CMI. The study committee of the Appleton League look forward to playing this role for the CMI locally and statewide.

Respectfully submitted,

Gretchen Bambrick, Chair
Mental Health Study
League of Women Voters of Appleton

CONCENSUS - MENTAL HEALTH STUDY - REPORT TO BOARD - 1991

Question #1.
Are community support programs (CSP) in your county(ies) for the seriously mentally ill adequate? in Wisconsin? If yes, explain: If no, explain:
Answer.
Given the numbers of people that need help and the fiscal restraints in the department, Outagamie County is doing an admirable job of serving the CMI. Areas of concern which were identified were: funding, staff shortages, high staff turnover, inadequate housing for CMI, the need for more levels or gradations of structure in housing and progressive care and people falling through the cracks of the system. Strong minority opinion advocated certification for the county.

Question #2.
Do you think community aids funding is adequate to meet the needs of the mentally ill in your county(ies)? If yes, explain. If no, would you be willing to put more resources into the CSP?
Answer.
We can't tell if the funding is adequate given the confusing format of the budget, the recent merging of the departments of Social Services and Human Services, and the restructuring of the budget allocations within the new department of Human Services. There is a concern about how the $1.2 million increased BCA will be spent.

Question #3.
Is the treatment of persons with mental illness in nursing homes and other in-patient settings adequate? If yes, explain. If no, why not?
Answer.
Treatment seems to be adequate locally at the moment but there is a concern that people will be removed from institutions inappropriately as a result of enforcement of OBRA regulations.

Question #4.
Would you change the commitment process to meet the needs of a person with mental illness who is dangerous to himself/herself or to others? If yes, should the process be more restrictive or less restrictive? Explain. If not, why not?
Answer.
The "sixth standard" would better meet the needs of the individual at an earlier stage of their illness, providing that a safeguard of assessment of each case be built in with a time limit for case review.

Question #5.
Should private insurance companies provide funding for community based programs for the mentally ill? If yes, why? If not, why not?
Answer.
No concensus. A strong minority opinion felt that payments for inpatient and outpatient treatment should include CSP.

Question #6.
Would you support community based mental health services for children/adolescents? If yes, how? If not, why not?
Answer.
Yes, definitely. Our education system has been set up to educate children, not deal with mentally ill children. The responsibility to deal with chronically mentally ill children/adolescents is misplaced in the school system. Their needs are not being addressed. Resources need to be allocated to expand human services and provide specialists for early diagnosis and early prevention.

Question #7.
Should mentally ill remain in jail for felonies and misdeamors? If yes, how should their treatment needs be met? If no, how should their treatment needs be met?
Answer.
Some should, especially those accused of felonies, but it depends on individual circumstances. We recommend continued training for police and sheriff's officers and the introduction of outreach services with the Department of Human Services.

Question #8.
Should federal funding focus on institutional care or on community based care? Explain.
Answer.
Federal funding should be allocated to areas of need. If funding is too heavy on institutional care, then too many people are "locked up" inappropriately; if funding is too heavy on community based programs, then too many patients are forced out of institutions inappropriately.

LWV - Mental Health Study Committee - 1989-90

Joanne Dull 824 Cambridge St. Appleton, WI 54915	731-8777
Judy Rehfeld 612 N. Owaissa St. Appleton, WI 54911	731-0082
Mary Cronmiller 19 South Meadow Dr. Appleton, WI 54915	739-2690
Sally Mielke 11 Reid Ct. Appleton, WI 54914	734-6228
Jeanie Trigg 1053 E. Nawada St. Appleton, WI 54911	734-7682
Mary Pat Thomson 2307 S. Carpenter Appleton, WI 54915	739-3279
Ann Dudley 425 E. Roosevelt St. Appleton, WI 54911	731-3554
Joanne Ross 2101 E. Lourdes Dr. Appleton, WI 54915	739-7608
Terri Miller 1117 E. Eldorado St. Appleton, WI 54911	731-0531

Ellen Needham 1940 Palisades Park Dr. Apppleton, WI 54915	734-5521
Barb Folb 525 W. Park Ridge Appleton, WI 54911	734-9627
Karen de Young 30 Bellaire Ct. Appleton, Wi 54911	739-3079 (h) 733-4481 (w)
Kathy Sprenger 916 E. Sunset Appleton, WI 54911	733-1227
Joy Povolny 31 S. Meadows Dr. Appleton, WI 54915	739-3846
Helen Nagler 932 E. Commercial St. Appleton, WI 54911	739-8053
Robyn Janson 1048 E. Eldorado St. Appleton, Wi 54911	731-4786
Vicki Ann Strand 331 S. Monroe Little Chute, Wi 54140	788-3172
Jane LaChapelle McCarty 1819 N. Superior Appleton, WI 54911	730-3815

Darci Vickman
2700 W. College Ave.
P.O.Box 1251
Appleton, WI 54912

731-5100 (w)
432-2381 (h)

GRETCHEN BAMBRICK
403 N. WOOD ST
APPLETON, WI 54911

735 9784

TO: LOCAL LEAGUE PRESIDENTS AND MENTAL HEALTH STUDY CHRS
FR: LWVW STATE BOARD AND THE MENTAL HEALTH STUDY COMM.

APPROVED LWVW POSITION ON MENTAL HEALTH CARE SERVICES TO BE ADOPTED AT STATE CONVENTION MAY 1991

In order to provide adequate mental health care services for persons with mental illness in Wisconsin, the League supports adequate funding for community support programs. Currently, funding focuses on institutional care. The League supports community based care when it meets the treatment needs of the client as a cost effective alternative to institutional care. We believe treatment should be eligible for federal funding in addition to current state and local law.

Counties struggling to maintain treatment standards for persons with mental illness need federal and state support monies to provide adequate care. The League recognizes the need to expand existent community based services--especially in the area of case management service to meet consumer needs and with an emphasis on specialized housing. The system is presently at capacity while at the same time clients are waiting to receive mental health services.

The League supports state-mandated benefits requiring private insurance companies to provide funding for community-based programs for the mentally ill.
We believe that Insurance companies should provide payments for participation in these programs, just as they do for other types of in-patient/out-patient treatment.

The league supports coordinated community based mental health services for children and adolescents.
Early treatment and prevention is vital. Only rarely do children presently get mental health care from public dollars as current state and federal funding is restricted to people aged 18-65 yr. old.

We support a coordinated approach to provide children and adolescents with mental health services. Many services are available now but there is no formal coordination in place among schools, hospitals, mental health clinics, social service departments, and child and adolescent protective services.

In a well coordinated delivery system, professional information would be shared ensuring that duplication of services does not occur while client confidentiality is protected.

League supports the civil commitment law which states:
In order to be civilly committed an individual must be: Mentally ill, drug or alcohol dependent or developmentally disabled and "a proper subject for treatment" and dangerous [see 51.20(1)(a)Wis.Stats.].

The four criteria of dangerousness are:

1. Probability of harm to self shown by recent threats or attempts at suicide or serious bodily harm.

2. Probability of physical harm to others as shown by recent violent behavior or threats placing others in reasonable fear of harm.

3. Probability of physical impairment or injury due to impaired judgement shown by a recent pattern of behavior.

4. Probability of serious physical harm because mental illness impairs the ability to satisfy basic needs [see 51.20(1)(a)2.a,b,c,d.Wis.Stats.].

The commitment law should be uniformly and consistently applied by legal professionals. The law is necessarily protective of both the rights of the individual and the public when considering "the right to the least restrictive conditions necessary to achieve the purposes of admission, commitment, or placement (Wis. Stat. Chap. 51)." We believe the enforcement of the "dangerousness standard" allows early intervention when judges and attorneys are educated and trained in mental health law application.

The league supports measures to assure prompt identification of incarcerated persons with mental illness.
This includes comprehensive training of jail personnel in recognition and care of persons with mental illness, assessment and jail diversion decisions by qualified staff, and appropriate treatment whether in jail or another facility.

LEAGUE OF WOMEN VOTERS MENTAL HEALTH STATE STUDY
DO YOU KNOW...?

1. Do you know that because of the strong committment from the Outagamie County Executive, 10% of the total county budget is allocated for Human Services?

2. Do you know that the Outagamie County Department of Human Services CSP cannot be certified by the state because they don't meet the staff to client ratio? (The standard requirement is 1 full time staff member for 18-20 clients. Human Services has 1 full time staff member for 28-35 clients.)

3. Do you know that the Outagamie County Department of Human Services has an average 4 week waiting list for the evaluation and psychotherapy unit and sometimes it is as high as 9 weeks?

4. Do you know that the Outagamie County Health Center serves the chronically mentally ill (who are in need of long term/"permanent" care) as well as those who are developmentally disabled?

5. Do you know that the state has mandated that the chronically mentally ill (CMI) in the County Health Centers be placed in the community setting sometimes within 2 years of their admission?

6. Do you know that the community programs which are highly structured ie: reward systems, special privleges, good conduct badges, etc. are most successful and least plentiful in our community?

7. Do you know that 92% of the residents in the Outagamie County Health Center are on Medicaid and 8-10% are private pay?

8. Do you know that the Community Outreach Center was set up 7 years ago to provide a place where people with CMI could go and belong and that the Center in 1989 had 13,000 visits, served 181 different people, held 245 planned recreational events (such as Bingo, instructional classes like cooking, picnics and Christmas dinner)?

9. Do you know that the Community Outreach Center is funded half by Outagamie County and half by Valley Packaging, which is also responsible for its own employment program, Custo Cleaning and some work with the homeless?

10. Do you know that the YMCA contracts with Villa Hope to rent apartments which it owns to the CMI who are on their own for the first time?

11. Do you know that the YMCA gives family memberships to all the group homes in the county/city?

12. Do you know that the Alliance for the Mentally Ill (AMI) donates furniture for the YMCA apartments and cleans them?

13. Do you know that the mentally ill population commit no more of the serious crimes than the "normal" population?

14. Do you know that most of the cases in the sheriff's office and the police department involving the mentally ill are cases of "disorderly conduct" or a person is acting in a "suspicious manner"?

15. Do you know that the state mandates that the certified officers in the sheriff's department must attend 40 hours of inservice training per year in both the legal and psychological aspects of dealing with the mentally ill and the Appleton Police Department provide instruction for the officers by utilizing Crisis Intervention personnel?

16. Do you know that the police will call Crisis Intervention (and CASI if alcohol is involved) to determine if a 72-hour detention is necessary and if it is, the arresting officer and other persons connected with the case (family, person issuing complaint, etc.) must appear before the judge at the committment hearing?

17. Do you know that the police do try to find and alternative for jail for persons with mental illness such as a 72 hour hold at St. Elizabeth Hospital or another mental hospital and sometimes they will try to persuade the individual to voluntarily commit himself?

18. Do you know that the CMI are Diagnostic Related Group (DRG) exempt at St. Elizabeth Hospital? (That is there are no restrictions for length of stay in relation to diagnosis)

19. Do you know that the psychiatric unit at St. E's is an acute care center only?

LEAGUE OF WOMEN VOTERS
MENTAL HEALTH STATE STUDY
DO YOU KNOW.....? (20 QUESTIONS)

1. Do you know that the Outagamie County Health Center is operating with 20 vacant positions?

2. Do you know that Lutheran Social Services has operated Edgewood House since 1986 as a licensed group home for chronically mentally ill men?

3. Do you know that 11 part-time para-professionals answer the phone 24-hours a day, everyday, at the Crisis Intervention Center?

4. Do you know that the Crisis Intervention Center receives 600-700 calls a month?

5. Do you know that the Winnebago Mental Health Institute doesn't take adults who are "just" mentally ill?

6. Do you know that the only agency servicing the mentally ill in this area that will accept Medical Assistance is Lutheran Social Services?

7. Do you know that the halfway house costs for mentally ill residents is about $32 to $38 per client per day?

8. Do you know that there is only <u>one</u> halfway house for mentally ill women in Outagamie County?

9. Do you know that a mentally ill person, sleeping on the street and eating garbage, cannot be committed against his will unless he is going to die from exposure?

10. Do you know that under present law a mentally ill person in a halfway house can refuse to take his/her medication?

11. Do you know that there is only one psychiatrist in Calumet County?

12. Do you know that Calumet County has no group homes for the mentally ill?

13. Do you know that Calumet County uses the Outagamie 24-hour Crisis Service?

14. Do you know that the mentally ill people from Calumet and Shawano Counties are moving into Outagamie County for services?

15. Do you know that the mental health professionals feel that in-patient psychiatric services are least successful?

16. Do you know that private psychiatric services locally do not accept Medical Assistance?

17. Do you know that it is virtually impossible to get mentally ill people, under the age of 65, admitted into nursing homes?

18. Do you know that mentally ill juveniles aged 14-18 must commit themselves for treatment?

19. Do you know that mental health case managers generally have caseloads of 30-40 clients?

20. Do you know there is a waiting list for a drug called clozaril?

/MANAGE - F

LEAGUE OF WOMEN VOTERS OF WISCONSIN
122 State Street, Madison, Wisconsin 53703-2500
(608)256-0827

September 1990

TO: Local League Presidents and Mental Health Study Chrs.
FR: Paula Anderson, Mental Health Study Committee Chr.
RE: Mental Health Study Guide and Consensus Questions

COORDINATION AND FUNDING OF SERVICES FOR THE MENTALLY ILL

FOCUS: Programs that directly affect the kind of services available to people with mental illness.

SCOPE: Examine the coordination of mental health programs and explore treatment services with the aim of assuring that at least minimal humanitarian services are extended to people with mental illness. Examine issues of community safety and the safety of the individual who is mentally ill.

Address and understand the financing of programs that affect people with mental illness with special note of those with chronic mental illness.

Consider the role of each level of government and the private sector in providing funding.

MENTAL HEALTH STUDY GUIDE AND CONSENSUS QUESTIONS

NOTE: The January 1990 Mental Health Supplement to the *Forward* is incorrectly labeled November 1989. Copies of the supplements are available from the League of Women Voters of Wisconsin State Office.

Definitions of terms: Glossary, page D, November 1989 and Glossary, page D, January 1990 Mental Health Supplement to the *Forward*.

1. Are community support programs(CSP) in your county(ies) for the seriously mentally ill adequate? in Wisconsin?
   If yes, explain:
   If no, why not:

Refer to the November 1989 Mental Health Supplement article "Community Support Programs;" September 1990, "Psychiatric Institution Release Laws;" and to the Wis.Admin.Code,HSS 63, April 1989, Community Support Programs for the Chronically Mentally Ill, and to your County Survey.

Discuss CSP standards and the case management system. How many programs are available in the county and who do they serve? Is the mental health consumer receiving necessary services? Include the elderly, unemployed, minorities, and the homeless in the population.

2. Do you think community aids funding is adequate to meet the needs of the mentally ill in your county(ies)?
If yes, explain:
If no, would you be willing to put more resources into the CSP?

Refer to the January 1990 Mental Health Supplement article "Funding of Programs Serving the Mentally Ill," "The Equity Issue," your county survey (budget and expeditures) and the interviews with key informants. Consider: Community Aids equity is now in place. How is your county using the 'new money?'

3. Is the treatment of persons with mental illness in nursing homes and other in-patient settings adequate?
If yes, explain:
If no, why not:

Refer to November 1989 Mental Health Supplement article "IMD and OBRA," and April 1990 "IMD and OBRA Update."

4. Would you change the commitment process to meet the needs of a person with mental illness who is dangerous to herself/himself or to others?
If yes, should the process be more restrictive or less restrictive? Explain.
If not, why not?

Refer to the September 1990 Mental Health Supplement and the article on "Civil Commitment." Civil commitment can become an emotional issue during discussion. Re-read the first paragraph in the Supplement article to define 'civil commitment.'

5. Should private insurance companies provide funding for community based programs for the mentally ill?
If yes, why:
If not, why not:

Refer to the September 1990 Mental Health Supplement, "Mandated Benefits for Treatment of Mental Illness." The question is whether the coverage by insurance companies should continue to be based on hourly counseling or whether it should include community support programs with a case management system.

6. Would you support community based mental health services for children/adolescents?
If yes, how:
If not, why not:

Consider: Youth are difficult to place in specific diagonostic Manual (DSM-III-R) categories. 'At risk' youth are currently receiving care through schools in special education classes, outpatient mental health clinics, and adolescent units at state hospitals.

7. Should the mentally ill remain in jail for felonies and misdemeanors?
   If yes, how should their treatment needs be met:
   If no, how should their treatment needs be met:

Refer to the November 1989 Mental Health Supplement article "The Mentally Ill in Jail," and the interview with the local sheriff.

8. Should federal funding focus on institutional care or on community based care?
   Explain:

While the question focuses on federal funding, you may choose to add a separate question substituting "state" for "federal."

Refer to the September 1990 Mental Health Supplement article on Mendota and Winnebago Health Institutes.

THE COUNTY STUDY: A SURVEY OF COUNTY MENTAL HEALTH SERVICES

INTRODUCTION:

The adopted study of the League of Women Voters-Wisconsin *Coordination and Funding of Services for the Mentally Ill* would be incomplete without an indepth look at county government and the County Department of Community programs. When Chapter 51 of the Wisconsin Statutes Mental Health Law came into effect, the county accepted responsibility for programs and services for the mentally ill. The administrative code rests with the State Department of Health and Social Services, Office of Mental Health, while the treatment, rehabilitation and the support services remain in the community where persons with mental illness live and work.

The county survey was developed for local leagues to gather background information to knowledgeably answer the consensus questions. Mental illness can become an emotional issue. The survey information received by the local league mental health committees, will be the basis for discussion of the adopted focus "*What are the programs that directly affect the kind of services available to people with mental illness?*" With facts about the community based care in the local league's county, each league can respond in a factual manner. The information from each county will then be compiled into a report available to all leagues.

The widely accepted premise of community based care for the mentally ill as the best form of treatment is dependent on whether the mental health consumer is receiving necessary services. After interviewing what are described as 'key informants' in the survey and looking at the budget and the local mental health plan, matching and comparing it to other expenditures for disabilities, examining the Community Support Programs for the Chronically Mentally Ill, and looking at the credentials of the professional people to whom we entrust their welfare and care, the complexities of the system and its basic design will become apparent.

The chairperson of the County Department of Community Programs (CDCP) also known as the 51.42 Board in some counties, is a key person in the survey and is an excellent contact for locating sources of other information required for the survey. The Mental Health Director for the county is another important resource as well as the local president of the Alliance for the Mentally Ill. If your county has a Mental Health Association, the chairperson of the organization can also provide information.

The county survey asks pertinent questions about the actual numbers of clients being served. How many people are in hospitals, day treatment facilities, county jails, and on waiting lists for care in the system? How do clients enter the system, and if in place, how does the case management system work?

League has found important public information by reading budgets, and in the survey, budget and expenditures by mental health program category, will help us understand where the money goes. Does the county provide or contract for the service? Who pays? The survey covers programs for adults and children\ adolescents. What are the credentials of the providers and what staff works with children?

The Community Support Programs are under scrutiny because the administrative code for CSP took effect April 1989. The counties are having difficulty in meeting the certification standards, yet the incentive to meet the standards in order to receive medicaid funding is present. What programs meet the standards, and what are the problems within the counties preventing certification?

Institutional care in the two state hospitals is paid for by the client's home county. How many clients were civilly committed to the state institutions from your county, and do you have problems with the commitment process in your county? This is a question that is appropriate to ask of the county system personnel and advocacy groups such as AMI and the Mental Health Association.

The final section in the survey refers to the mentally ill in jail after arrest. Does your county have a screening process to identify the mentally ill, and is the forensic staff trained in procedure to meet their needs?

The complete County Study Survey will be sent to local presidents and Mental Health Committee chairs January 1990, along with a study guide for the consensus questions. Each local league will have a state Mental Health Committee person to contact for any problems or questions about the survey. The League cannot survey all the counties in the state since we do not have local leagues in every county. If your county has more than one League, network to divide the task of collecting information for the study, and prepare joint meetings to discuss the issues.

A completed survey of your county will offer answers to the questions of quality of care for the mentally ill.

THE COUNTY STUDY: A SURVEY OF COUNTY MENTAL HEALTH SERVICES.

COUNTY_____

WHAT IS THE COUNTY POPULATION?_____

TEAM FOR INTERVIEWS: (MINIMUM OF TWO SUGGESTED)

_____ _____

LEAGUE:

DATE:

TO COMPLETE THE STUDY OF **COORDINATION AND FUNDING OF SERVICES FOR THE MENTALLY ILL**, WE NEED TO TURN TO THE COUNTY GOVERNMENT. THIS SURVEY IS A MEASUREMENT TOOL PROVIDING CONCISE ANSWERS TO ANALYZE THE SERVICES AVAILABLE IN THE COUNTIES. THE COMPLETED SURVEY WILL SERVE AS AN INFORMATIONAL SOURCE TO LOCAL LEAGUES FOR DISCUSSION AND WILL OFFER THE NECESSARY BACKGROUND TO REACH CONCENSUS. THE INFORMATION COLLECTED FROM ALL THE LEAGUES WILL BE COMPILED INTO A REPORT WITH A VIEW TOWARDS PUBLISHING AFTER THE LWV-W CONVENTION IN 1991. IF YOUR COUNTY HAS MORE THAN ONE LEAGUE, NETWORK TO DIVIDE TASK AND MEET WITH THE OTHER LEAGUES FOR DISCUSSION.

I. KEY INFORMANTS:

*THE TITLES OF THE KEY INFORMANTS MAY VARY BECAUSE COUNTY SYSTEMS ARE ORGANIZED DIFFERENTLY. IN SOME COUNTIES THE COUNTY DEPARTMENT OF COMMUNITY PROGRAMS IS REFERRED TO AS THE 51.42 BOARD OR THE UNIFIED BOARD OR A SIMILAR NAME.

QUESTIONS TO ASK OF THE KEY INFORMANTS:

1. ARE COMMUNITY SUPPORT PROGRAMS IN THE COUNTY ADEQUATE TO MEET THE NEEDS OF THE MENTALLY ILL?
2. WHAT PROGRAMS DO YOU THINK MEET WITH SUCCESS? WHY?
3. WHAT PROGRAMS HAVEN'T WORKED? WHY?
4. HOW ARE YOU MEETING THE NEEDS OF THE MENTALLY ILL HOMELESS?
5. WHAT IS THE HOUSING AVAILABILITY FOR THE MENTALLY ILL?
6. ARE THERE PROBLEMS IN THE COUNTY WITH THE COMMITMENT LAWS?

7. ARE THERE WAITING LISTS FOR SERVICES? HOW MANY AND FOR WHAT SERVICES? WHAT IS THE AVERAGE LENGTH OF TIME ON THE LIST?

8. HOW MANY ADULTS WITH SERIOUS MENTAL ILLNESS ARE THERE IN YOUR COUNTY?

9. HOW MANY CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE IN YOUR COUNTY?

KEY PERSONS TO INTERVIEW:

(RECORD EACH INTERVIEW ON A SEPARATE SHEET)

A. CHAIRPERSON COUNTY DEPARTMENT OF COMMUNITY PROGRAMS (CDCP)

B. DIRECTORS AND STAFF OF COUNTY DEPARTMENT OF COMMUNITY PROGRAMS (CDCP)

C. BUSINESS MANAGER OF COUNTY DEPARTMENT OF COMMUNITY PROGRAMS (CDCP)

D. COMMUNITY SUPPORT PROGRAM DIRECTORS

E. DIRECTOR OF COUNTY INPATIENT PSYCHIATRIC UNIT\HOSPITAL

F. DIRECTOR OF COUNTY INSTITUTE FOR MENTAL DISEASES (IMD)

G. MENTAL HEALTH CENTER DIRECTOR

H. ALLIANCE FOR MENTALLY ILL (AMI) - LOCAL PRESIDENT

I. PRIMARY CONSUMERS - FAMILY MEMBER

J. MENTAL HEALTH ASSOCIATION

K. SHERIFF

L. DIRECTOR OF COUNTY SOCIAL SERVICES AGENCY

II. DOCUMENTS TO ASK FOR:

A. COPY OF THE CURRENT YEAR'S BUDGET (COMPLETE)

B. LOCAL MENTAL HEALTH PLAN WITH ORGANIZATIONAL FLOW CHART

C. ANY REPORTS WRITTEN REGARDING COMMUNITY SUPPORT PROGRAMS

III. INFORMATION TO REQUEST:

A. LOCATIONS OF PERSONS WHO MEET CSP CLIENT DEFINITION:

HSS 63.08 CRITERIA FOR ADMISSION. Admission to a CSP shall be limited to an individual who has chronic mental illness which by history or prognosis requires repeated acute treatment or prolonged periods of institutional care and who exhibits persistent disability of impairment in major areas of community living as evidenced by...(WISC. ADMIN.CODE HSS 63 308-10)

1) NUMBERS: OUT OF COUNTY PLACEMENTS

2) NUMBERS: INPATIENT
INSTITUTE FOR MENTAL DISEASES (IMD)
NURSING HOME
SPECIALITY HOSPITAL
COMMUNITY SUPPORT PROGRAMS (CSP)
OUT PATIENT
DAY TREATMENT
COUNTY JAILS
WAITING LISTS

B. FLOW CHART: HOW DO CLIENTS ENTER THE SYSTEM?
WHAT IS THE CONTINUITY OF CARE?
IS THERE A CASE MANAGEMENT SYSTEM?
HOW DOES IT WORK?

C. HOW DOES THE COUNTY SYSTEM PROVIDE COORDINATION BETWEEN MENTAL HEALTH AGENCIES AND ADULT PROTECTIVE SERVICES/VOC-REHAB/LAW ENFORCEMENT? FOR CHILDREN BETWEEN CHILDREN'S SCHOOLS/CHILD WELFARE/JUVENILE JUSTICE?

IV. BUDGET:

A. MENTAL HEALTH BUDGET FOR CURRENT CALENDAR YEAR AND EXPEDITURES FOR LAST COMPLETED YEAR FOR COMPARISON

B. TOTAL COUNTY BUDGET BY ALL DISABILITIES FOR CURRENT CALENDAR YEAR AND EXPENDITURES FOR LAST COMPLETED YEAR WITH NUMBER OF PERSONS SERVED

C. MENTAL HEALTH BUDGET AND EXPENDITURES BY PROGRAM CATEGORY LISTED ON THE NEXT PAGE:

ALSO ASK, DOES COUNTY PROVIDE OR CONTRACT FOR THE SERVICE? WHO PAYS?

ADULTS:

1. INPATIENT
2. COMMUNITY SUPPORT PROGRAMS
3. OUTPATIENT
4. RESIDENTIAL
    a. GROUP HOME
    b. SUPPORTED APARTMENTS
    c. ADULT FAMILY HOMES
5. DAY TREATMENT
6. INSTITUTION FOR MENTAL DISEASES
7. PREVENTION OR INTERVENTION
8. CRISIS INTERVENTION
9. VOCATIONAL SERVICES

CHILDREN/ADOLESCENTS:*

*NOTE: SOME OF THESE QUESTIONS NEED TO BE DIRECTED TO THE COUNTY SOCIAL SERVICES DEPARTMENT

1. INPATIENT
2. OUTPATIENT COUNSELING
3. RESIDENTIAL CARE
    a. GROUP HOME
    b. CHILD CARE INSTITUTION
4. DAY TREATMENT
5. EARLY INTERVENTION/PREVENTION
6. CRISIS SERVICES
7. INTENSIVE IN-HOME TREATMENT
8. RESPITE CARE
9. CASE MANAGEMENT
10. TREATMENT PROGRAM THAT INCLUDES: SCHOOLS, MENTAL HEALTH AGENCIES, AND SOCIAL SERVICES

D. ALL COUNTIES PROVIDE A LOCAL "MATCH" OF 9.89% OF THE BASIC COUNTY ALLOCATION (BCA) PORTION OF COMMUNITY AIDS. SOME COUNTIES SPEND ADDITIONAL MONIES. WHAT IS THE BUDGETED AMOUNT OF COUNTY 'OVERMATCH' FOR MENTAL HEALTH COMPARED TO OTHER DISABILITIES?

E. FOR WHICH PROGRAM CATEGORIES UNDER C, IS THE OVERMATCH BUDGETED AND FOR HOW MUCH MONEY?

F. WHAT ARE AMOUNTS OF SPECIALIZED DOLLARS: COMMUNTY OPTIONS PROGRAM (COP), NURSING HOME RELOCATION FUNDS, (MA) MEDICAL ASSISTANCE FOR CASE MANAGEMENT, (MA) MEDICAL ASSISTANCE FOR COMMUNITY SUPPORT PROGRAMS (CSP), SUPPLEMENTAL SECURITY INCOME-EXCEPTIONAL EXPENSE(SSI-E) MONIES?

V. LIST ALL COUNTY PROVIDERS OR CONTRACT PROVIDERS FOR MENTAL HEALTH SERVICES AND THE SERVICES THEY PROVIDE

A. HOW MANY OF THESE ARE CERTIFIED TO PROVIDE MEDICAL ASSISTANCE PROGRAMS?

B. NUMBER OF CLIENTS SERVED BY EACH PROVIDER IN THE LAST YEAR

C. NUMBER OF PERSONS MEETING COMMUNITY SUPPORT PROGRAMS (CSP) CRITERIA SERVED BY EACH PROVIDER IN THE LAST YEAR.

VI. COMMUNITY SUPPORT PROGRAMS (CSP):

A. NAMES OF CSP OPERATED BY OR UNDER CONTRACT TO COUNTY

B. WHICH PROGRAMS MEET CSP CERTIFICATION STANDARDS?

C. HOW MANY WILL REQUEST CERTIFICATION IN 1990?

D. HOW MANY WILL ATTEMPT TO MEET STANDARDS IN 1990?

E. WHAT IS THE DEFICIENT PROGRAM AREA?

a. Staff to client ratio
b. No clinical coordinator
c. Lacking array of services
d. Is staff certifiable? If not, why?
e. Other

VII. OF THE CLIENTS IN YOUR COUNTY WHO MEET COMMUNITY SUPPORT PROGRAM (CSP) ADMISSION CRITERIA IN NURSING HOMES (HOW MANY?) WHY ARE THEY THERE? WHAT MENTAL HEALTH SERVICES DO THEY RECEIVE?

*EFFECTIVE APRIL 1, 1990, ALL MENTALLY ILL PERSONS RESIDING IN A NURSING HOME MUST BE EVALUATED TO DETERMINE IF THEY REQUIRE ACTIVE TREATMENT. IF THE NEED FOR ACTIVE TREATMENT IS INDICATED THE PERSON MUST BE DISCHARGED AND HAVE TREATMENT PROVIDED.

HOW MANY ANNUAL REVIEWS WILL YOU BE DOING?

VIII. WHAT INPATIENT PROVIDERS DO YOU USE FOR PERSONS WHO MEET THE COMMUNITY SUPPORT PROGAM (CSP) CRITERIA?

A. WHAT IS THE AVERAGE LENGTH OF STAY FOR EACH HOSPITAL?

B. HOW MANY DAYS OF INSTITUTE CARE AT MENDOTA AND WINNEBAGO DID YOU PURCHASE FOR PERSONS WHO MEET THE COMMUNITY SUPPORT PROGRAM CRITERIA IN THE LAST CALENDAR YEAR?

IX. COMMITMENT:

A. WHAT IS THE NUMBER OF CLIENTS CIVILLY COMMITTED IN YOUR COUNTY IN THE LAST CALENDAR YEAR?

B. WHAT ARE THE NUMBER OF CLIENTS ON CHAPTER 55?

C. HOW MANY CLIENTS ARE COMMITTED TO THE 51.42 BOARD (OR ITS EQIVALENT) UNDER CHAPTER 51 AND CHAPTER 55?

X. WHAT SERVICES ARE AVAILABLE AFTER HOURS AND ON WEEKENDS?

XI. WHAT IS THE NUMBER OF CLIENTS FOUND MENTALLY ILL IN JAIL AFTER ARREST? IS THERE A SCREENING PROCESS? WHAT IS IT?

A. WHAT IS THE LENGTH OF STAY IN JAIL?

B. HOW ARE POLICE OFFICERS AND STAFF TRAINED IN PROCEDURE OF MEETING THE NEEDS OF THE MENTALLY ILL?

THE CONSUMER SURVEY

The November Forward Supplement introductory article on Mental Illness carried a final statement saying,"Consumers are often not able to be their own advocates or guides." Betty Blaska, a consumer specialist, responded with, "This is a common perception and it may very well be true--but it's one that we mental health consumers are trying to change." (Personal letter Nov. 14, 1989)

WIMMEHC (Wisconsin Network of Mental Health Consumers) sponsored a Consumer Conference in Madison, October 1989, inviting participation of consumers and professionals throughout Wisconsin. The focus was "Reclaiming Our Strengths--Building on Our Experiences>" The Annual Conference drew 130 consumers from 23 counties in Wisconsin.

To interview primary consumers, AMI (Alliance for Mentally Ill), Mental Health Association, and PREVAIL (Psychiatric Reform through Education, Visionary Action, and Intense Lobbying) will be able to arrange contacts with consumers who want to talk to the Leagur. (Organization phone numbers listed in Resources) Waivers regarding privacy, confidentially, perhaps a family member present are part of the process.

A Consumer is a 'key informant.' (See county study) The numbers of consumers interviewed are not important, but the opinions of consumers and the feelings they share are. The study committee did not mandate consumer interviews because of the time needed to do an adequate job collecting information for the total county survey, but suggest this as time allows.

These are important questions to ask in the consumer interview:

1.What service does the consumer receive in the system?

2. Service needs:

a. Treatment: Was the client/consumer's input regarding the treatment process welcomed?

Who does the client see for treatment? How often? Where?

b. Housing: Where does the client live?

What proportion of the client's total income goes to housing costs?

c. Medications: Is the client on medication?

How satisfied is she/he with the medications?

d. Employment: Does the client have meaningful employment? Number of hours

e. Financial Support: Is it adequate to meet basic needs?

3. Does the client have a wish list?

RETURN COPIES OF THE SURVEY TO THE LWV-W OFFICE AS SOON AS COMPLETED. ANTICIPATED COMPLETION OF THE COUNTY SURVEY: THE SPRING OF 1990 IF AT ALL POSSIBLE.

QUESTIONS ABOUT QUESTIONS? CONTACT THE MENTAL HEALTH STUDY COMMITTEE. EACH LEAGUE HAS A DESIGNATED COMMITTEE PERSON READY TO ANSWER ANY QUESTIONS.