Master Plan for the

Public Sector Mental Health System

or Adults in Milwaukee County

Prepared for the

Milwaukee County Department of Human Services

by

Susan Besio, Ph.D.

Center for Community Change Through
Housing and Support
Institute for Program Development
Trinity College of Vermont
Burlington, Vermont

December 15, 1993

MILWAUKEE COUNTY MENTAL HEALTH MASTER PLAN
PROJECT STAFF

This Master Plan for Mental Health Services in Milwaukee County was completed by staff of the Center for Community Change through Housing and Support, a national technical assistance and training center located in Burlington, Vermont, project consultants, and individuals in Milwaukee County who helped staff this project. Following is a list of these individuals, their role in the project, and their employment affiliation (although their work on this project was outside of their normal work capacity). All inquiries concerning content of this document should be directed to Susan W. Besio, Ph.D., Associate Director, Center for Community Change through Housing and Support, IPD / Trinity College, 208 Colchester Avenue, Burlington, Vermont, 05401, (802) 658-0000.

Susan W. Besio, Ph.D.
Master Plan Project Director
Associate Director
Center for Community Change
Burlington, Vermont

Jerome Blakemore, Ph.D.
Project Consultant and Staff
School of Social Welfare
University of Wisconsin - Milwaukee
Milwaukee, Wisconsin

Paul J. Carling, Ph.D.
Project Consultant and Staff
Executive Director
Center for Community Change
Burlington, Vermont

Thomas S. Fox, M.D.
Project Consultant
Medical Director
State Division of Mental Health
Concord, New Hampshire

Carol Hale
Project Secretary
Department of Human Services
Milwaukee, Wisconsin

Pablo Hernandez, M.D.
Project Consultant
Hospital Administrator
Las Vegas Medical Center
Las Vegas, New Mexico

Edward jj Olson
Project Consultant and Staff
President
E jj Olson & Associates, Inc.
Milwaukee, Wisconsin

Constantine Panagis, M.D.
Project Consultant and Staff
Vice President
E jj Olson & Associates, Inc.
Milwaukee, Wisconsin

Estelle Richman
Project Consultant
Director, Office of Mental Health
City of Philadelphia
Philadelphia, Pennsylvania

Beth Tanzman, M.S.W.
Project Consultant and Staff
Mental Health Consultant
Center for Community Change
Burlington, Vermont

Richard L. Tully, Jr.
Project Consultant and Staff
Director of State Operated Services
Ohio Department of Mental Health
Columbus, Ohio

ACKNOWLEDGEMENTS

Nearly 300 Milwaukee County citizens directly contributed to the development of this Master Plan for Mental Health Services in Milwaukee County. Department of Human Services and Milwaukee County Mental Health Complex staff were essential throughout the project. In particular, Kathie Eilers, Milwaukee County Mental Health Complex Administrator, and Paul Radomski, Director of the Mental Health Bureau of the Adult Services Division, Department of Human Services, were instrumental in bringing this project to completion: they provided the guidance, insight and information to make it a realistic plan for citizens of Milwaukee. Special mention also must be given to Lori Grant, Fiscal Department, Mental Health Complex, and Paul Radomski for their vital assistance with fiscal and service utilization information; they were always extremely helpful and responsive under frequently very demanding timelines.

The project was advised by the Master Plan Committee, which met monthly to provide input and guidance to the plan content. Their commitment to quality mental health services in Milwaukee County was evident throughout the project, and their concerns and recommendations form the basis of this plan. A list of the Master Plan Committee members follows this page. Appendix A contains minutes of the Master Plan Committee meetings.

Twelve focus groups also were held during the project, and approximately 231 people participated from throughout the county. These meetings provided invaluable insight about the existing services and needs within Milwaukee County, and many of the recommendations in this plan are derived from those suggested by focus group participants.

In addition, approximately 34 key informants from throughout the county, including consumers / ex-patients, family members, professionals and others, were interviewed by he consultants, either by telephone or in face-to-face meetings. These individuals were very forthright in the information they provided, both about their own services or organizations, as well as about the current state of mental health services in Milwaukee County. Their input was extremely beneficial to the development of this plan. Five individuals also allowed us to interview them about their experience with mental illness and the current Milwaukee County service system. We thank them for their openness and insights.

The Project Staff also reviewed a number of documents produced in the past few years about mental health services in Milwaukee County. Appendix B contains lists of Key Informant Interviews, documents reviewed by project staff, and focus group meetings and minutes.

A special thank you is extended to the Grand Avenue Club, which hosted most of the Advisory Committee Meetings. The members were very gracious in making room for us each month, and the lunches and snacks were delicious!

MASTER PLAN COMMITTEE MEMBERS

John Bartowski
Executive Director
Sixteenth Street Community
Health Center

Kathleen Borders
Executive Director
Alliance for the Mentally Ill

Shirley Bracey
Consumer

George Braunstein
Manager, Mental Health Services
Family Health Plan

Sergeant Douglas B. Campbell
Milwaukee Police Department

Bruce Christiansen, Ph.D.
Assistant Medical Director
Blue Cross / Blue Shield

Joseph Cooper
DOA Fiscal Affairs

Lynne DeBruin
Supervisor
County Board Offices

Kathleen Eilers
Administrator
Mental Health Complex

Jon E. Gudeman, M.D.
Medical Director
Mental Health Complex

Thomas Hlavacek
Wisconsin Coalition for Advocacy

Ann Jones
Bell Therapy

Julie Jorgensen
Federation of Nurses & Health
Professionals

Maria Ledger
Department on Aging

Roz Libman
Alliance for the Mentally Ill
Family Member

Paula Lucey
Doyne Hospital Association
Administrative Patient Services

Sinikka McCabe
Director, DHSS
Wisconsin Bureau of Mental Health

Gail McCelland
Department on Aging

Bill Mollenhauer
AFSCME, District Council 48

Vickie O'Reilly
Consumer

Candice Owley
President
Federation of Nurses & Health
Professionals

John Palmer
Executive Director
Human Services Triangle

Harry Prosen, M.D.
Professor and Chairman
Psychiatry & Mental Health Sciences
Medical College of Wisconsin

Paul Radomski
Manager, Mental Health Bureau
DHS Adult Services Division

Karen Robison
Executive Director
Mental Health Association

Gregory Schmidt, M.D., Ph.D.
Associate Professor & Vice Chairman
Dept. of Psychiatry, UW Medical School
Sinai Samaritan Medical Center

Suzanne Schuler
MHC Director of Nursing

Brad Smith
Consumer Advocates for Mental Health

Barbara Stefonek
Administrator
Ancillary Home Health Care

In addition, the following individuals were Advisory Committee Members, but were only able to attend two meetings or less:

Sara Greenberg
Consumer Advocates for Mental Health

Lee Holloway
Supervisor
County Board Offices

John Karfonta
Health & Safety Coordinator
Milwaukee Police Department

Robert Kessler, D.O.
Medical Director
Quad-Med Clinic

Jan Kuenning
Consumer

Madelyn Lazich
Consumer Advocates for Mental Health

Patricia McManus
Executive Director
Black Health Coalition

Matthew Pietz
Consumer

Stephanie Stein
Director
Department on Aging

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

FIGURES: **Page**

MASTER PLAN FOR THE PUBLIC SECTOR ADULT MENTAL HEALTH SYSTEM IN MILWAUKEE COUNTY

EXECUTIVE SUMMARY

The County of Milwaukee is unique within Wisconsin. It is the only urban center in the state, with a total population in 1990 of 965,067, of which 712,741 were 18 years or older; approximately 24% (172,415) of those over 18 are over the age of 60. The county, located on Lake Michigan's western shore, covers 242 square miles, and is comprised of 19 municipalities. The City of Milwaukee, which is the primary municipality in the County, has a total population of 629,554, making it the nation's 17th largest city. The population of Milwaukee County also is culturally diverse: 75% of the population is white, 20% of the population is African-American, 2% is Asian and Pacific Islander, 1% is American Indian, and 2% are of other races. In addition, 5% of the population is of Hispanic origin (which may be of any race). In Milwaukee City, however, only 63% of the population is of the white race. The median household income for the county in 1989 was $27,867, although this varies widely by municipality, ranging from $23,627 in Milwaukee City to $110,712 in River Hills village. As such, in order to be effective, public sector mental health services must address the needs of a very diverse, urban population.

Milwaukee County is at a crossroads in determining the future direction for its public mental health system for adults. Over the past several years, a number of assessments and reports were commissioned to examine various aspects of the County's public mental health services. Although these studies indicated a general dissatisfaction with the existing public mental health service system in Milwaukee County, the complexity of the issues involving mental health service delivery made it difficult to affect any meaningful systemic change. As such, when the Department of Health and Human Services (DHHS) reorganized in 1990 to become the Department of Human Services (DHS), it was decided that the County's mental health system should undergo a separate analysis from the DHHS reorganization process.

In 1991, as part of the second phase of the DHS reorganization, efforts began to look at the County's public mental health service system for adults. It was determined that a master plan for public sector mental health services for adults in Milwaukee County should be developed to establish a philosophy of care; assess service need; describe how the County could allocate resources to meet these needs; and determine the most effective organization of services to implement the plan. This document is an effort to respond to the need acknowledged by the County Board of Supervisors and the Department of Human Services for such a Master Plan.

This Plan does not address the needs and services for children and youth with serious emotional disturbance, or for persons with developmental disabilities. It is strongly recommended that the County of Milwaukee engage in similar planning efforts for these populations in the immediate future.

Development of the Master Plan was based on the following assumptions:

- The County of Milwaukee wants a comprehensive mental health service system, in which both inpatient and community-based services offer state-of-the-art, quality care for adults with serious mental illness. Therefore, the county wants a comprehensive plan that will chart a clear set of directions to achieve this goal.

- The County of Milwaukee wants a well-coordinated mental health system in which all service components work together to achieve continuity of care for the service recipient.

- The County of Milwaukee wants a mental health plan that facilitates an effective use of resources through improved accountability.

- The County of Milwaukee wants a fixed point of responsibility for service provision with clear roles, responsibilities, and authority.

- The County of Milwaukee wants its mental health service delivery system to be based on, and responsive to, the stated needs and preferences of its citizens with serious mental illness, and to be responsive to the needs of families.

- The County of Milwaukee is willing to develop a plan that is based on the needs and desires of people with mental illness, rather than on maintaining the status quo of existing provider agencies.

- The County of Milwaukee wants a mental health plan that builds on the planning already accomplished through previous efforts, and which addresses the practical challenges of implementing planning principles and goals.

- The County of Milwaukee believes that both quantitative and qualitative information is needed from a variety of sources to truly understand the strengths and weaknesses, and thus needed changes, in the service delivery system.

- There may be no new resources to develop new services. Therefore, the County of Milwaukee wishes to develop a service plan that is realistic within existing financial constraints, but that also allows services to be revised to meet the needs of the county's citizens. The County also understands that new resources would enable the system to make greater strides towards achieving a responsive, comprehensive service system.

- The County of Milwaukee believes that service system changes cannot happen effectively unless all stakeholders are actively involved in the planning process.

In order to develop a Master Plan for the public sector mental health system in Milwaukee County, information was gathered about the strengths and weaknesses of the adult service system. In addition to the very informative discussions and guidance from the Master Plan Advisory Committee during the ten months of the planning project, individual interviews were held with 33 key informants throughout the County, approximately 230 individuals participated in 13 focus groups focused on this issue, and recent documents and reports written about the service system were reviewed by the consultants.

The public sector mental health system for adults in Milwaukee County has a number of strengths to provide the foundation for a comprehensive, well integrated service system focused on meeting individual consumers' needs. There is a collective understanding of the need to develop an integrated system of services that focus on consumer outcomes rather than on program maintenance. There also are a number of individual services in existence that have proved effective in helping people with mental illness to avoid the need for crisis intervention and inpatient care.

There are many issues within the system, however, that prohibit individuals from getting appropriate and effective services in a timely and cost-efficient manner. The FY92 public sector mental health system for adults in Milwaukee County is bifurcated in terms of service development, management, and resource allocation, with two different administrative organizations having responsibility for county and non-county based services. This administrative structure prohibits system-wide planning, fiscal oversight, information collection, or accountability. There also have been few resources directed towards enhancing the workforce to assist in the provision of relevant and effective services.

In addition, services have developed in a non-integrated manner, with little attention to overall system needs. Much of the service system is focused on office-based outpatient services, medical day treatment programs, a single crisis response service, and acute and long-term inpatient care. There also has been some limited development of more outreach services, such as Community Support Programs, short-term evaluation and triage capacities, a psychosocial rehabilitation clubhouse, and vocational assistance. As a result, the system directs most of its resources to inpatient and office-based services, rather than outreach and wrap-around services which can prevent individuals from needing more intrusive, disruptive and expensive forms of care.

There are a variety of revenue sources with which to provide services for people with mental illness in Milwaukee County. Thus, the County has the capacity to examine and then revise the system based on its current service strengths and identified needs.

This Master Plan presents recommendations according to three of the key areas which are essential to the development and maintenance of an effective service delivery system: 1) the formation of a clear statement of vision, mission and service delivery principles that is shared by all major constituents in the relevant geographical area, and that guides service system development and implementation; 2) clear identification of services to be provided for specific target populations and the relationships between the individual service components; and 3) the development of administrative structures and supports to ensure that the service system functions in a way that achieves the vision, mission, and principles.

VISION, MISSION, AND GUIDING PRINCIPLES

One of the most important elements of a well-integrated, effective service system is a shared understanding, and explicit statement of, the outcomes desired for consumers of the mental health system (Vision), the role of the mental health system to help consumers achieve these outcomes (Mission), and shared values about what qualities make services effective (Principles). These Vision, Mission, and Principles are the guiding force of the service delivery system, and provide all constituents with a clear understanding of what everyone is trying to achieve. As such, they are the foundation of all service development and delivery, and should be used to hold the system accountable in every way.

During the course of the planning project, the Master Plan Advisory Committee developed and adopted the following vision and mission to guide the Milwaukee County public sector adult mental health system policies, organization, resource distribution, program development, service delivery, program outcomes, and evaluation.

The **VISION** of the mental health system serving the people of Milwaukee County is that the citizenry function at optimal levels of physical and mental health, and that individuals who have mental illness are full and equal members of the community. As such, the system shall provide individuals who have mental illness the support and the means to pursue success in the ways they choose to live, learn, love, work and play.

It is the **MISSION** of the mental health system serving the people of Milwaukee County to develop, coordinate, and provide multiple resources to help achieve this Vision. The resources are to include: a full range of quality risk reduction, diagnostic, treatment, and rehabilitation options; safe and affordable housing; learning, work, social and recreational opportunities; family and peer support; and self-help services. Implementation of this Mission will include the promotion of positive images of people with mental illness through the use of appropriate, non-stigmatizing language; and opportunities for positive contributions by consumers and family members in all aspects of service system governance, planning and delivery, including employment in the service delivery system.

The **GOAL** is to develop, direct and manage a readily-accessible and respectful system of community and hospital support services that assist persons who have a mental illness to:

1) acknowledge, learn about, cope with, and recover from their illness;
2) gain skills and access to support systems to live independently;
3) have access to the best possible mental health services;
4) take responsibility for directing their own lives as members of the community; and
5) have opportunities for making positive contributions to the mental health service system and to their community.

NUMBERS IN NEED OF PUBLIC SECTOR SERVICES

To plan effective service systems, it is necessary to develop an estimate of the numbers of people in each target population who will need services in a given period of time. This enables resources to be allocated in appropriate proportions to meet this need, and also can be used as an indicator of whether the system is meeting the needs of the population it is intended to serve. Using national urban prevalence rates, the estimated number of adults with severe mental illnesses in Milwaukee County who need public sector mental health services at a given point in time is 11,208 (1.6% of the County's adult population), while the number of adults with non-severe mental disorders who would want to access public sector mental health services at a given point in time is 14,048 (2% of the County's adult population).

TARGET POPULATIONS

Increasingly, mental health service systems are targeting public resources to persons most in need (i.e., people with severe mental illness). In addition, they are defining specific subpopulations who have specific service needs, based on diagnosis, severity of functional impairment, and duration of functional impairment. Definition of these subpopulations allows more accurate estimation of the need for specific services. It also helps the system ensure that those who receive intensive resources are the people who are most in need. Following are the target populations proposed for Milwaukee County:

GROUP 1: Persons with Severe and Persistent Mental Illness (N= 4,753)

Persons in this group are recently severely impaired and the duration of their severe impairment totals six months or longer.

GROUP 2: Persons with Severe Mental Illness (N= 1,459)

Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

GROUP 3: Persons who were Severely Impaired (N= 4,996)

Persons in this group are not recently severely impaired but have been severely impaired in the past and need some on-going services to prevent relapse.

GROUP 4: Persons with Mild or Moderate Mental Disorders (N= 14,048)

Persons in this group either 1) have disorders that are not as severe in terms of diagnosis, duration or disability as those in Populations 1, 2, and 3, or 2) formerly had a mental illness resulting in severe impairment but no longer need intensive services to prevent relapse. Persons in this group are typically individuals whose lives are extremely stressed by the combined effects of poverty, violence and drug abuse, and that present at mental health services with exacerbations of mental disorders due to these stresses or acute emotional reactions to interpersonal conflict or disruption. As such, even though these individuals do not have a severe mental illness, they do need services to avert greater needs.

The service recommendations contained in this Master Plan are based on the use of these four target population groups, with the assumption that people within these groups will have similar service needs. This methodology also assumes that these estimates represent the total number of people in each of these groups at any given point in time. It does NOT imply that an individual cannot change from one service need category to another. These estimates are only meant to be used as tools for planning at the systemic level. In fact, the primary assumption underlying all recommendation within this plan is that continuity of caregiver and service flexibility are at the core of the service delivery system.

THE SERVICES

In order to achieve the Vision and Mission, major changes need to occur within the mental health system in Milwaukee County. Current services have been developed without a functional mechanism for unified administrative oversight and without a clear focus on the desired outcomes for consumers. This has resulted in a system that is reactive rather than proactive; focused on maintaining services and programs rather than on assisting people in their own environments; and, using resources in a manner that is revenues inefficient rather than cost efficient in terms of service quality and outcomes for consumers.

The service components proposed for the comprehensive public sector mental health service system for adults with mental illness in Milwaukee County are shown in Figure 1.

Figure 1

KEY SERVICE COMPONENTS OF THE PROPOSED PUBLIC SECTOR MENTAL HEALTH SERVICE SYSTEM FOR ADULTS IN MILWAUKEE COUNTY

RISK REDUCTION PROGRAMS	WELLNESS/REHABILITATION SERVICES	PRE-CRISIS SERVICES	CRISIS RESPONSE/ STABILIZATION SERVICES	INPATIENT SERVICES
• Family/ Child Programs, Wellness Education	• **24 Hour Referral/ Triage Telephone #** • **Intensive Community Services Assessment Program** • Short-term Eval/Triage (CCLP)	• **Assist Team**	• **Mobile Crisis Team**	• Mental Health Complex
• Public MH Education/Referral	• CSPs (Intensive Needs) • **Targeted Case Management** • Geropsychiatric Triage • COP • **Benefits Coordination** • **Flexible $ Pool**	• **Warmline**	• **Mental Health Police Liaison**	• General Hospitals
• **Other Identified Needs**	• Housing * Regular Housing with Supports * CBRFs	• **Respite Apt for Clients and Families**	• Hotlines/Crisis Lines	• State Mental Health Institutes
	• Health Management/Alternatives * Home Health Care	• **In-Home Childcare Respite**	• **Crisis Specialists (in home)**	
	• Daytime Activities * Vocational/Occupational/Educational * Psychosocial Clubs/ Drop-In Centers * Day Treatment	• Homeless Outreach Services	• **Crisis Apartment (several days)**	
	• Consumer Support/ Education/Advocacy * **Primary Consumers** * Families	• Jail/Forensic Services	• Emergency Room Walk-Ins (General Hospitals, Psychiatric Emergency Rooms)	
	• Income Management	• Dual Diagnosis Services	• Psychiatric Crisis Services (24 hr evaluation, hospital-based)	
	• Outpatient Clinics * Counseling * Medication Management			
	• Alternative Counseling Services			

NOTE: Proposed new service components are shown above in **bold**. In addition, each of the existing service components is proposed to be either enhanced or decreased.

Risk Reduction Programs

In FY92, 0.33% of all revenues in the public sector mental health system were allocated to four organizations which specifically focus on risk reduction activities. The activities provided by these four organizations included early intervention services to support high risk families, work-site wellness programs, coping skills education, suicide and depression prevention programs, and education and information directed towards the general public about mental health issues, symptoms, and service resources. As noted by the Final Report of the Milwaukee County Task Force on Prevention and Early Intervention, providing resources for these kinds of activities is extremely effective in the long-run, in that they can prevent or diminish the probability of individuals developing mental-emotional disabilities in the future. Unfortunately, because these programs do not provide direct services to individuals experiencing a disruptive disability or problem, resources for these activities are often the first to be reduced in times of fiscal constraints. In reality, to stop the trend toward higher demands for human services in our current society, these risk reduction activities should be protected at all costs.

It is recommended that the revenues for risk reduction activities be increased to $752,349 within the next five years. Under the revenue assumptions of this Master Plan, this would result in a 550% increase in tax levy and community aids revenues allocated to these activities by DHS (from $88,452 to $482,463). The remaining revenue amount of the FY92 and proposed totals is revenue collected by the programs themselves.

Funded activities should include, but not be limited to, parent education and support; stress management in the workplace and in the home; coping skills for elders, for people with disabilities or medical illnesses, and those undergoing extreme situational stress, and their families; and education in schools and in the general community about mental illness. All of these programs have shown to be effective in reducing risk of future emotional disturbance. Since mental-emotional disorders involve all aspects of a persons life, it is important that risk reduction efforts be funded and coordinated across all relevant departments and community organizations, such as Education, Youth Services, Aging, Drug and Alcohol, and Health.

Wellness / Rehabilitation Services

The vision of the Milwaukee Mental Health System is that individuals with mental illness will be full and equal members of the community, and that the system shall provide them the support and the means to pursue success in the ways they choose to live, learn, love, work and play. As such, a primary emphasis of the service system should be on having an array of resources that will assist individuals with mental illness to maintain wellness, to acquire or regain skills that assist them to achieve their goals, and to avert the need for intensive crisis or inpatient services. In addition, access to these resources should be coordinated so that the person receives service and supports in a timely and responsive manner, and that they are the appropriate service to meet the person's needs. The services recommended in this Master Plan reflect this goal.

Access for any new person needing or requesting services will be available through a 24 hour information and referral telephone line. This model for access and referral is used very successfully in a number of comprehensive urban service systems throughout the United States. Information and Referral Phone Line staff screen calls to assess whether they are routine, in the sense that the person wants information or referral to mental health services, or whether the call concerns someone experiencing a crisis. In essence, this Information and Referral Line is the primary point of access into the public mental health service system, and performs a vital system coordination and integration role. This telephone line will be staffed by two Masters-level Psychologists / Social Workers or Psychiatric Registered Nurses three shifts a day, seven days a week, and will interface with the Department on Aging Information and Assessment Line for persons over 60.

At the core of a good wellness and rehabilitation service system is a primary person or team of persons, on whom the individual with mental illness can rely for support, counseling, assistance with daily living activities, and service access and coordination. The person(s) is also the key information source for overall system evaluation and planning, in terms of being most knowledgeable about client outcomes and service gaps. In Milwaukee County, this service will be provided either through CSPs or through Targeted Case Management services. Access to these resource intensive services will be provided through a Community Assessment Program, designed to screen and refer appropriate individuals to CSP or case management services. Staff from this program will meet with each individual who has been referred for CSP or case management services, and conduct an interview and diagnostic assessment to determine whether these services are appropriate for the individual. The person will then be linked with the CSP or case management provider that can best meet their specific needs, or be assisted to access other relevant services within the system.

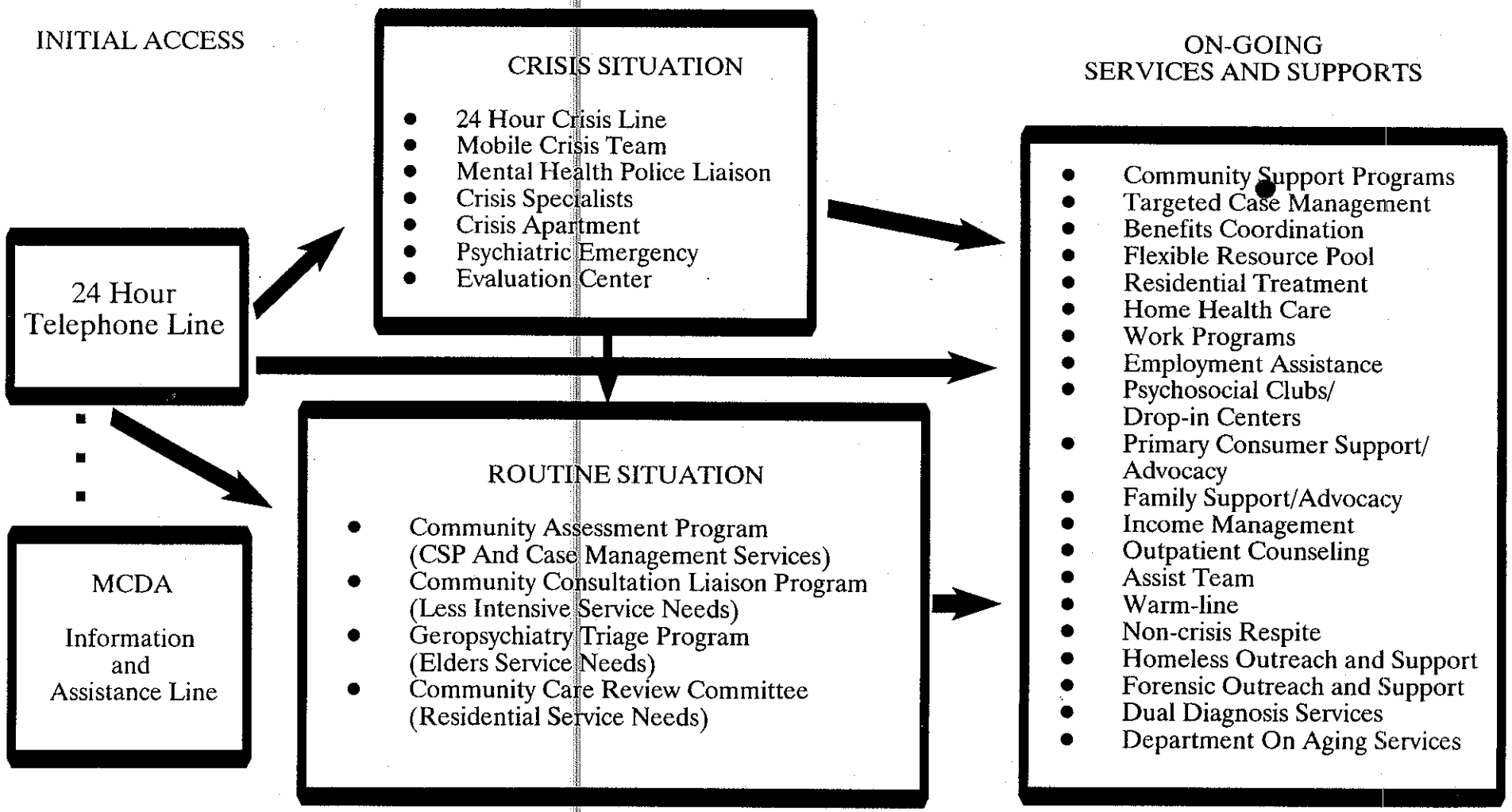
In addition to the Community Assessment Program (CAP), there will be several other assessment and referral programs to help individuals access appropriate services. These include the existing Community Consultation Liaison Program (CCLP), which provides assessment and triage for people who have less intensive needs than those who need CSP or case management services; the existing Geropsychiatry Triage Program, which provides outreach assessment and triage for elders; and the existing Community Care Review Community, which reviews referrals for residential treatment programs. Each of these triage components has a unique expertise, and will play a vital role in coordinating access to various services to meet individuals' special needs.

There also will be a variety of direct services available to individuals in the four target groups. These include Benefits Coordination; a Flexible Resource Pool; Residential Treatment Programs; Home Health Care; Work Programs; Employment Assistance; Psychosocial Clubhouse Programs; Drop-in Centers; Family and Consumer Self-advocacy Peer Support, and Education; Income Management Assistance; Outpatient Counseling and Medication Management; paraprofessional Assist Team; Warm-line; Non-Crisis Respite; and Outreach and Support Services for people who are Homeless, who have forensic involvement, who have substance abuse issues, and who are elders. These services can be accessed by directly contacting a provider agency or by getting referrals from one of the assessment and triage components discussed above. (See Figure 2).

Figure 2

FUNCTIONING OF PROPOSED SERVICE SYSTEM

IN VIVO ASSESSMENT AND TRIAGE



t:\ta\chart\assesmna.cht

Pre-Crisis Services

In addition to assisting individuals to maintain wellness, some services are focused specifically on recognizing when an individual may be developing either environmental or physical problems which might result in increased symptoms, and if not attended to, ultimately, the need for intensive crisis intervention services. In such cases, they attempt to address the issue before it develops into a more serious situation. A number of services already discussed also perform the role of supporting someone in this situation (e.g., CSPs, case management, home health care, outpatient clinics). However, more targeted services also need to be developed for this purpose, including an Assist Team, a Warmline, non-crisis Respite Services, and services for people who are homeless, who have involvement with the correctional system, or who have issues with substance abuse as well as mental illness.

Crisis Response / Stabilization Services

The services in this category are available to assist an individual when their situation has escalated to the point that they need immediate intervention to assess the problem and develop mechanisms for resolution. There are several different options for accessing this type of assistance: a mobile crisis intervention team to respond to a situation on an outreach basis; assistance from the Mental Health Police Liaison; "walking in" to the general hospitals' emergency rooms or the specialized psychiatric emergency rooms; or calling a twenty-four hour hotline. The role of each of these services is to assess and try to diffuse the immediate situation, and then triage to back-up support services (crisis specialists or crisis respite apartment) or less intensive services (e.g., Pre-Crisis Services), if possible, or more intensive services (Crisis Stabilization Services), if needed.

Once a person has accessed immediate crisis response services, and it has been determined that their situation cannot be adequately addressed through triage to less intensive pre-crisis or wellness services and supports, they will have access to crisis stabilization services. These services provide short-term (usually 24 to 48 hour) interventions that focus on timely, accurate assessments of the issues which have led to the crisis, good clinical diagnoses and evaluations, and triage with necessary follow-up services. Again, every effort is made to avert the need for more intrusive inpatient stays. Crisis stabilization services in Milwaukee County will be available to be provided in the person's home, in a respite situation, or in a clinical setting.

Adult Inpatient Services

Public sector inpatient services for adults with mental illness in Milwaukee County are primarily provided by MHC, although some ASD resources are allocated to inpatient services for individuals with mental illness in nursing homes or the State Institutions.

Within the overall system in Milwaukee County, there has been no focused role for inpatient services. As a result, MHC has traditionally functioned as the primary resource to address intensive needs. There is an open intake gate, resulting in a large number of adult acute admissions each year. In addition, the average daily census is much higher than many of the "model" urban mental health systems in the country. Patients in both the acute and rehabilitation units also often have longer lengths of stay than may be necessary, due in part to the unavailability of rehabilitation beds for people from acute units, inadequate resources for discharge planning, and overall system values focused on client maintenance rather than growth. This over reliance on inpatient services not only affects client outcomes, but also results in low staff morale within the inpatient service system. As a result of this, MHC is already undergoing a down-sizing effort which is expected to be completed by May, 1994.

FY92 AND PROPOSED PUBLIC SECTOR ADULT INPATIENT CAPACITIES

	FY1992 CAPACITY	MAY, 1994 CAPACITY	PROPOSED CAPACITY
GENERAL ACUTE STABILIZATION	96	96	60
ACUTE: GEROPSYCHIATRIC	48	48	24
DOYNE HOSPITAL UNITS	48	48	48
DUAL DIAGNOSIS (MI / SA)	55	66	24
REHABILITATION	320	192	84
WESTVIEW NURSING HOME	4	4	0
WISCONSIN STATE INSTITUTES	4	4	5
TOTAL INPATIENT BED CAPACITY *	575	458	245
TOTAL / 100,000 ADULT POPULATION = 712,741	80.7	64.3	34.4

* Total does not include inpatient services for children and youth, or for persons with development disabilities.

The proposed maximum capacity of 245 inpatient beds was based on several factors. First, almost two-thirds of a 10% random sample of MHC inpatients were estimated by MCMHC staff as appropriate candidates for community placement, given the existence of a comprehensive service system, and more than a third appropriate for placement even without a comprehensive service system. Given the representativeness of this sample, this implies that about two thirds of the residents of MCMHC (at the time of the assessment) could function in the community with a comprehensive community support service system in place, leaving approximately 224 people who need inpatient care at any given time.

The recommendation of a maximum of 245 inpatient beds was also derived by consulting with two nationally recognized experts on inpatient services, who visited Milwaukee Count during the course of this project: Dr. Tom Fox, Medical Director for the New Hampshire Department of Mental Health, and Pablo Hernandez, Las Vegas Medical Center Hospital Administrator. It should be noted that the proposed capacity results in a capacity of 34.4 beds per 100,00 adult population, which is still substantially higher than that achieved by other comprehensive systems in the country. It also should be noted that this recommendation is not only based on a rationale of effective resource allocation, but more importantly, on providing proactive services and supports to each citizen of Milwaukee County who has a mental illness so that they do not need as much intrusive, facility-based care.

As the Department of Human Services begins implementation of this Master Plan, it also will be important to consider the role of general hospital psychiatric services within the public sector system, since these hospitals are already serving people who receive federal entitlements, and have therefore shown interest in addressing the needs of people who typically use public sector services, they may also be interested in service expansion in this area.

ADMINISTRATIVE STRUCTURES AND SUPPORTS

Reorganization of the Department of Human Services

As noted previously, in Milwaukee County there is no single fixed point of authority with the resources or focus to pro-actively address the needs of the mental health system. In Milwaukee, the Department of Human Services has the ultimate authority for the mental health system. However, the Administrator of this Department has responsibility for all child welfare, juvenile corrections, adult disabilities and public welfare services, with the exception of Adult Corrections and Aging. Within the Department of Human Services, the Adult Services Division oversees the Mental Health Bureau (which has primary responsibility for all mental health services other than those delivered through the Mental Health Complex), Alcohol and Drug Abuse, Developmental Disabilities, Physical Disabilities, and Access and Brief Services. A separate division, the Mental Health

Division, oversees all services provided by the Mental Health Complex. As such, there is no fixed entity with a single focus on mental health which also has the responsibility to oversee ALL mental health services (those offered by the county-operated Mental Health Complex and those offered through provider agencies which contract with ASD). The result is a fragmented system, without the ability to develop comprehensive plans or policy, integrate / coordinate services, monitor service quality, coordinate with the State Bureau of Mental Health on state initiatives / policies, attend to Health Reform issues in the County, or target and be accountable for fiscal resources.

This lack of coordinated planning and the ability to develop a unified, proactive budget results in unfocused service development. There is little understanding between ASD and MHC and Milwaukee County Department on Aging (MCDA) about revenue sources and allocation, and the methodologies used for fiscal tracking differ significantly. As such, it is not possible, without a significant degree of staff time and effort, to develop a fiscal picture which reflects the total resources within the mental health system in Milwaukee County. In addition, since MHC is County-owned, all MHC budget deficits are automatically covered by tax levy funds, with the remaining tax levy dollars allocated to fund all ASD contracted programs. This situation results in limited funding for community-based programs, a perpetuation of the reliance on inpatient services as the primary mode of care, and a wariness on the part of the County Board of Supervisors to fund new or innovative programs or services.

It is strongly recommended that the structure of the Department of Human Services be reorganized to provide a mechanism to address these concerns. It is recommended that the structure be realigned to create a new Adult Mental Health Division within the Department of Human Services, with a designated Division Administrator and staff to adequately fulfill the responsibilities of planning, budgeting, contracting and monitoring service provision. The Division would have oversight over all adult mental services, in that it would consist of a County Services Bureau, comprised of the county-operated Mental Health Complex, and the Contract, Planning and Evaluation Bureau, which would contract with private provider agencies and with MCDA for persons over the age of 60.

The Department of Human Services would still have five Divisions, but the Mental Health Division (which is totally comprised of the Milwaukee County Mental Health Complex) would become the County Services Bureau, and would function under the oversight of the proposed Mental Health Division. The Mental Health Bureau, which is one of five Bureaus within the Adult Services Division, would shift to become the Contract, Planning and Evaluation Bureau of the proposed Adult Mental Health Division, and would continue in its current role, as well as have new responsibilities. As such, this re-organization does not create any new administrative structures, but instead realigns existing structures to provide one administrative organization with the authority and resources to implement a unified adult mental health service delivery system within Milwaukee County.

A primary effect of this realignment is that county-run services would be overseen by an entity (the Division of Adult Mental Health) which would make service development and funding decisions based on overall system needs, rather than based on two separate systems with competing financial interests, uncoordinated service development, incomparable financial and service utilization reporting mechanisms, and little accountability for resource utilization.

Because MHC provides almost all public sector mental health services for Children and Youth in Milwaukee County, there are at least two options for addressing this issue in the proposed DHS reorganization. First, the Youth Services Division could contract with MHC for these mental health services, using a similar procedure to that proposed within the Adult Mental Health Services Division. An alternative approach would be to give authority for all mental health services, with the exception of those addressed by the Department on Aging, to the new organizational entity, thereby creating a Mental Health Division with oversight for all contracted and county-run mental health services for persons under the age of 60. Since this planning process did not include services for children and youth, the best approach to deal with this issue is unclear. However, the proposed DHS reorganization for adult services should not be delayed due to this issue, in that temporary agreements or arrangements can be made while this issue is resolved.

It also is strongly suggested that a similar planning effort begin immediately to examine the public sector mental health system for children and youth in Milwaukee County. Although they often function as two separate systems, they interface very directly in a number of ways. One obvious interface is the service provision to both populations by MHC. In addition, many of the individuals who receive mental health services as children and youth will transition to the adult mental health service system to continue receiving services; therefore, these two systems often serve the same people at different points in their life. One implication of this is that the values on which service are based must be consistent for the two systems, and services should be designed which reflect these shared values and service approaches.

Consumer Outcomes

Traditionally, the focus within mental health systems has been to maintain existing programs, and to develop models of service delivery based on the requirements of funding sources in order to continue revenue receipt. Recent national trends, however, focus on providing high quality care and effective resource utilization, as is evidenced by the emphasis on managed care in the health delivery system. All the recommendations in this Master Plan move the Milwaukee County public sector mental health system in this direction.

At the heart of this plan is the assumption that all services should focus on achieving positive outcomes for the people they serve, and that funding sources and strategies are mechanisms for achieving these outcomes. Survival of programs or provider agencies should be dependent on the quality of the services they provide, measured in terms of consumer outcomes and satisfaction. The Adult Mental Health Division must develop mechanisms to provide both information on consumer outcomes and on consumer and family satisfaction with services. Without such information, it is impossible to monitor whether the system is using its resources to effectively meet the needs of its service recipients.

Such key consumer outcomes include increases in rates of consumer employment, at which consumers receive income support and entitlements, at which consumers achieve desired and decent housing, and at which consumers are actively engaged in natural support networks; and decreases in symptomatology, crisis service and hospital utilization rates, numbers of days spent incarcerated and/or homeless, and rate of substance abuse. These outcomes also should be aggregated across all service components by the Adult Mental Health Service Division to assess system effectiveness and identify gaps.

Satisfaction measures should focus on consumer and family opinions of service quality, including indicators of service accessibility and responsiveness; flexibility based on individual needs; respectfulness; cultural and ethnic sensitivity and relevance; emphasis on consumer choice and involvement; and other values which are contained in the Guiding Principles. There are a variety of methods for collecting this information, including surveys, focus groups, attending family and consumer meetings, and developing consumer satisfaction teams which visit programs and speak directly with consumers and family members, and see the services first-hand.

Management Information System

A good management information system is a vital component of any successful service system, in terms of quality, cost effectiveness, and client satisfaction. Currently such a system does not exist in Milwaukee County. For example, obtaining and summarizing the revenue information for this planning project was challenging for the project consultants and for the MHC and ASD staff who provided it to the consultants. There also is minimal ability to track service use of individual clients, to identify people who use / need intensive services, or to identify unduplicated count of people receiving services in a given timeframe. In addition, the current data system does not provide adequate information about patients, including previous hospitalizations, medications, community service use, and so forth. As a result, there is little ability to know important clinical information (e.g., case manager, relevant previous history, current medications, allergic reactions) when someone accesses a new service component or is in crisis.

To address this vital need for a mechanism to monitor service utilization and to provide necessary clinical information about individuals receiving service, the Adult Mental Health Division needs to create a standardized data and management information system, with individual, unique client identifiers, that can be implemented at contract agencies and at MHC. This system should be developed to maintain individual confidentiality, as well as have the ability to evaluate program outcomes. It also should be used to provide timely information to the provider system about the performance and service use and needs within the public sector mental health system in the County. Such Management Information Systems recently have been implemented within other areas of the Milwaukee community, including the community general hospitals, municipal and circuit courts, the Milwaukee Police Department and the Milwaukee Health Department.

Performance Contracting

It is recommended that the Adult Mental Health Division use a Request for Proposal (competitive bidding) process and performance contracting to develop new community-based services and to continue to fund all those community-based services that currently exist, including all those provided by MHC and other county-operated agencies. It is vital that proposals first be reviewed based on established technical specifications to meet the desired service quality and characteristics (e.g., mode and location of service delivery, staffing ratios, intended consumer outcomes, involvement of consumers and family members in design and implementation of service, cultural and ethnic competence, adequacy of staff salaries and benefits, and so forth), and then those that meet the technical specifications should be reviewed according to proposed cost. Without using technical specifications as the preliminary review criteria, RFP processes are subject to relying on a "low cost bidder" approach which may result in service development that is also of low quality and/or has inadequate supports for staff to be able to achieve positive outcomes.

All services, including inpatient and community-based services, should be provided through a performance contracting mechanism which would hold providers accountable for outcomes and resource allocation. Use of such performance contracting procedures will enable the Division to contract with providers based on comparable service quality expectations, fiscal and service utilization data, and outcomes for the individuals being served. The annual review of these contracts should be based on the agency's performance regarding expected outcomes for consumers and adherence to standards developed to reflect the Guiding Principles for the service delivery system. Ultimately, performance contracting with all providers could allow the Division to develop a capitation system of managed care.

Capitation Initiatives

The combination of having clear target population definitions, using a RFP process for all services, and performance contracting with all providers could allow the Division to develop a capitation initiative for people with the most severe needs. In capitation systems, all funds are consolidated in one pool and a predetermined amount is allocated to providers who contract to meet all the needs and achieve desired outcomes for specific groups of individuals (i.e., long stay inpatient residents). In capitated systems, the provider is responsible for effective utilization of the allocated resources across all individuals for all services needed by each person (including community and inpatient services), thus encouraging more proactive service provision to prevent the need for more intensive, costly reactive services. In essence, it is a managed care approach to serving people with the most intensive needs, but one that focuses on consumer outcomes rather than on funding source requirements.

Master Plan Advisory Committee

It is strongly recommended that DHS maintain the Mental Health Master Plan Advisory Committee beyond the completion of the planning project to oversee implementation of the Plan, advise the Adult Mental Health Division, and keep a proactive focus on the system's vision and mission. This committee could continue as a free-standing group, or could become a committee of the existing Combined Community Services Board, with the charge of being the entity which is focused specifically on mental health concerns. Such Advisory Committees have been used very successfully in other locations to assist implementation of system change initiatives and Master Plans.

County Board of Supervisors

In order to better serve the demands on, and needs of, the County Board of Supervisors, it is recommended that a new free-standing Mental Health Committee be created within the County Board to focus specifically on mental health issues. This entity would interface between the full County Board of Supervisors and the Department of Human Services Director, the Adult Mental Health Division, and other Divisions or Bureaus which serve people with mental disorders.

Human Resource Development

Staff are the "bricks and mortar" of high quality, responsive mental health service delivery systems. Unfortunately, most mental health systems, including Milwaukee County, focus little attention or resources on maintaining or enhancing this vital element of service effectiveness. For example, the annual staff development budget of the Mental Health Complex is $14,000 for its staff, and the Adult Services Division has no dollars directly

allocated for this purpose. As such, it is extremely difficult to recruit and retain a workforce that is adequately skilled, culturally relevant, and dedicated to helping people with mental illness achieve their desired outcomes.

Implementation of this Master Plan cannot be successful without a strong focus on the human resource development needs within the system. New staff will need to be recruited and trained (Recruitment and Pre-service Training) and existing staff will need to learn new skills and be given opportunity for advancement (In-service Training and Redeployment Opportunities). This Master Plan proposes that the newly re-organized Division of Adult Mental Health have 1.0 FTE staff to focus on human resource development needs, with a $250,000 annualized budget for staff training and development.

MHC Staffing Needs

In FY92, there were 1,702.5 FTEs employed at the Milwaukee County Mental Health Complex. Of these, approximately 767 provided direct care on the adult inpatient units. With the proposed reductions in this plan, approximately 315 of these direct care staff might be affected by the inpatient downsizing. (It should be noted that a number of FTEs have already been decreased due to the downsizing efforts which have occurred since the end of FY92 and which are planned for FY94; these FTEs are a portion of the 315 FTEs referred to above). Many areas around the country have successfully downsized without having staff layoffs, through natural attrition, vacancies, and aggressive redeployment strategies to community-based services. It is recommended that actions be taken immediately to educate MHC inpatient staff about the direction of the Master Plan for two purposes: (1) to help them understand the rationale behind the plan's recommendations and dispel any myths about the proposed service shifts that may have occurred during the planning project, and (2) to begin a process of identifying staff who may be interested in providing community-based care. The service enhancements continued in this plan will require a significant increase in the workforce within the overall public mental health system, and the skills and expertise of many of the inpatient staff would be an asset to the quality of service delivery. They would especially be valuable staff for CSPs and case management focused on the needs of people discharged from inpatient settings.

Ethnic Competence and Cultural Diversity

The mental health service system in Milwaukee must attend to issues of both cultural and ethnic competence, in that this area has been neglected in the past years. As a result, there are few provider agencies which have services targeted specifically to people of color or from various ethnic or cultural backgrounds or age. In addition, recruitment and employment of staff who are of color must be a priority, since they are currently very under-represented within the workforce. This is especially true at the management level, where effective policy and service planning requires input from individuals with this perspective.

In order to develop proactive strategies to address these needs, the Adult Mental Health Division must take leadership to encourage and promote agency-level cultural and human competency in all policy development activities; develop and implement policies that ensure equity in service funding, access, and quality of care for persons of color, persons with differing disabilities, and persons with a same sexual orientation; identify and promote strategies for recruitment and retention of persons from diverse cultural groups at all levels in the mental health service delivery system; make sure that mental health professional education includes content on issues of cultural diversity; and set a standard for hiring mental health professionals who have prior training in cultural diversity, or provide cultural diversity training as part of their initial orientation. The mental health service delivery system also should hold accountable administrative and provider organizations for promoting cultural competence and value diversity through the contracting and evaluation mechanisms.

Consumer Involvement

People with direct experiences in the mental health / illness system (as either ex-patients or active service recipients) and their family members have unique contributions to make toward improving the quality and function of the mental health system. They are the most knowledgeable resources for providing information about what is working well and what needs to be improved. The mission statement for the Milwaukee Mental Health System Master Plan reflects the importance of consumer involvement in all areas of the mental health system. As stated in this Mission statement, a primary goal of the system should be the promotion of positive images of people with psychiatric disability through the use of appropriate non-stigmatizing language, opportunities for making positive contributions, and employment.

Consumers should have active and vital roles in the agencies and organizations which collectively constitute the mental health system. To realize this goal, the involvement of consumers as board members should be mandated for all mental health agencies receiving a majority of their funds through the Adult Mental Health Division. Initially, the number of consumers per agency should be at least two, but agencies should establish as a goal 50% consumer governing board membership. This also should be a requirement for any committee or board of the Adult Mental Health Division, including the Master Plan Advisory Committee and CCSB. This involvement of consumers must be assured through the provision of supports. These supports must be financial in the form of stipends, a per diem and / or funds to assist with transportation cost. Functional supports should also be made available for consumers. Functional supports might include preparation for meetings or post meeting follow-up.

The mental health system also should establish on-going mechanisms for obtaining and updating information to gain insight about its effectiveness and the needs of consumers. One such mechanism is to formally and regularly obtain written information from active ex-patient / consumer and family organizations related to their concerns about the mental

health system. These formal assessments should solicit consumer and family recommendations about ways for improving services.

In addition, the administrative staff of the Adult Mental Health Division and of provider agencies should establish regular meetings with local family and consumer groups on a monthly or bi-monthly basis. This allows the key decision-makers within the system to have direct information about service improvements and needs.

Consumers and family members also should be included in the design and implementation of service evaluation activities, and a component in evaluating mental health provider agencies should include their efforts at updating and obtaining information about the needs of consumers.

The system should have as a value the employment of consumers of mental health services, in ways that are not nominal or that promote tokenism. Within the context of this employment, consumers should have assess to supportive work environments and climates. To realize this value, the agencies should be encouraged to create jobs specifically for consumers. In addition, paraprofessional training programs must be developed that have as a goal the transfer of consumer paraprofessionals into professional staff positions. To adequately support consumer staff, procedures must be developed for assuring reasonable accommodation. Non-consumer staff also may need on-going training or other mechanisms for exploring the usefulness of, and how to provide assistance with, the integration of consumer staff into the workforce.

In order to assist with the above efforts, and to assure that consumer involvement is at the forefront of all activities of the Adult Mental Health Division, it is recommended that a Consumer Affairs Specialist be hired within the Division. In addition to the above activities, this staff would help consumers throughout the county develop support groups, respond to Requests for Proposals to provide consumer-operated services, and so forth. A budget of $48,900 has been allocated to the DHS reorganization costs to assist with these activities.

FISCAL SHIFTS AND BENEFITS

The service system outlined in this Master Plan is one that is derived from the Vision, Mission and Guiding Principles set forth by the Master Plan Advisory Committee. It is based on the experiences of model system throughout the country, but is adapted to reflect the culture, values and existing service system in the county of Milwaukee. The proposed service system would enable Milwaukee County to assists its citizens with mental illness to have full lives, and to prevent them from having to reach the point of crisis before receiving services. It also would provide the administrative supports to assure a system that is efficient, effective, and responsive to the needs of its consumers and the needs of its staff.

All of the proposed changes can be achieved with the same amount of revenues available in the Milwaukee County public sector adult mental health system in FY1992, with two exceptions. First, there may be outstanding crosscharges currently incurred by MHC that would no longer be needed within the mental health system, and this may have an impact on other county organizations or departments. In addition, revenues are not included for the one-time costs of approximately $2,208,000 to develop the proposed Management Information System for the adult mental health system, including MHC and contract agencies. With these two exceptions, redistribution of *existing* revenues, plus new tax levy dollars approved in November, 1993 by the County Executive to be allocated over the next five years for a Lawsuit Settlement, would enable the County of Milwaukee to implement all of the recommendations in the Master Plan, including the proposed new or enhanced services; the DHS administrative reorganization; funds for staff training, consumer involvement, service evaluation activities, and on-going maintenance of the MIS; and an allocation to fund crosscharges purchased by MHC in FY92 which would continue to be needed within the adult mental health system, regardless of MHC service capacity. The redistribution of these resources is shown in Table 1.

As can be seen in Table 1, the cost for this proposed service system requires no other new resources from the County of Milwaukee. In fact, resources allocated from the Milwaukee County Health Care Financing Program in FY92 are projected to decrease by $3.5 million over the next five years if the proposed service system is developed, of which approximately $1,926,000 is tax levy funds. This analysis also accounts for over two-thirds of the county crosscharges incurred in FY92 by MHC through services received from other county organizations, and strategies to address the remaining third are discussed.

The proposed plan also would result in a shift from allocating 61% of the system's existing resources on inpatient services - which are extremely expensive, intrusive, and an indication of poor services to prevent crises and hospitalization - to allocating 69% of the resources on more proactive and humane community-based services which can assist Milwaukee County's citizens with mental illness to achieve much more productive and meaningful futures.

Table 1

COMPARISON OF FY92 AND PROPOSED REVENUE TOTALS BY SOURCE

REVENUE SOURCE	FY1992 COMMUNITY	FY1992 INPATIENT	FY1992 TOTAL	PROPOSED COMMUNITY	PROPOSED INPATIENT	PROPOSED NEW ADMIN	PROPOSED TOTAL	NET CHANGE (PROPOSED–FY92)
CSP–STATE	$500,627		$500,627	$500,627			$500,627	$0
MENTAL HEALTH BLOCK GRANT	$67,294		$67,294	$67,294			$67,294	$0
COMMUNITY AIDS	$21,346,948	$679,282	$22,026,230	$21,551,473	$474,757		$22,026,230	$0
TAX LEVY	($4,204,532) a	$14,024,077 a	$9,819,545 a	$3,038,406	$6,537,248	$2,092,355	$11,668,009	$1,848,464 b
FEDERAL FORENSIC	$182,464		$182,464	$182,464			$182,464	$0
IMD	$472,720	$7,069,366	$7,542,086	$6,493,681	$1,048,405		$7,542,086	$0
FEDERAL PATH FUNDS	$181,015		$181,015	$181,015			$181,015	$0
GOVERNMENT PURCHASE	$753,511		$753,511	$542,677			$542,677	($210,834)
TITLE 18	$962,623	$5,510,702	$6,473,325	$2,315,378	$3,177,163		$5,492,541	($980,784)
TITLE 18/TITLE 19	$1,314,901	$1,560,422	$2,875,323	$930,995	$876,933		$1,807,928	($1,067,395)
FEDERAL TITLE 19	$213,615		$213,615	$8,968,924			$8,968,924	$8,755,309
FEDERAL–STATE TITLE 19	$3,842,077	$6,010,558	$9,852,635	$2,268,382	$1,955,826		$4,224,208	($5,628,427)
FEDERAL–LOCAL TITLE 19	$354,691		$354,691	$457,233			$457,233	$102,542
HEALTH CARE FINANCING PLAN	$880,464	$7,583,987	$8,464,451	$880,464	$4,082,934		$4,963,398	($3,501,053)
COP	$921,706		$921,706	$921,706			$921,706	$0
SELF PAY	$1,625,739	$168,871	$1,794,610	$1,088,887	$49,576		$1,138,463	($656,147)
MISCELLANEAOUS	$1,898,364	$6,589,571	$8,487,935	$2,293,471	$5,093,889		$7,387,360	($1,100,575)
TOTAL W/O NEW ADMIN COSTS	$31,314,227	$49,196,836 a	$80,511,063	$52,663,077	$23,296,733		$75,979,810	
% OF TOTAL REVENUES	38.9%	61.1%		69.3%	30.7%		100%	
TOTAL WITH NEW ADMIN COSTS				$52,656,688	$23,296,733	$2,092,355 c	$78,072,165	($2,438,900)
% OF TOTAL REVENUES				67.4%	29.8%	2.8%		

a Accounts for $4,627,140 in Tax Levy revenue targeted for community based services, but applied to inpatient services, by MCMHC

b Amount of new Tax Levy apporved for Law Suit Settlement to be allocated over five year period

c New Admin costs include:

$338,390	DHS Reorganization (New Staff)
$398,900	DHS Reorganization (Consumer Activities, Staff Training, Service Evaluation)
$513,992	MIS On–Going Maintenance
$841,073	Outstanding County Cross–charges needed by Mental Health System, but not allocated to specific service components
$2,092,355	

As previously noted, it is difficult to know how many unduplicated individuals receive public sector mental health services in Milwaukee County. What IS known is that a majority of the adults are primarily seen after they are in crisis, or through office-based clinic appointments that often are not very effective as the primary treatment modality for most persons with mental illness. As a result, the service system is in gridlock, with people cycling in and out of crisis and existing services, with no room for others in need to receive help. In contrast, the proposed service system is based on national urban prevalence estimates of the numbers of persons who should be expected to need public sector mental health services in the County at a given point in time, and the proposed service capacities are based on serving these people with the kinds of treatment approaches that have been found to be very effective. By receiving these services, "persons with severe mental disorders will be able to participate more productively at home, at work, and in the community" (National Advisory Mental Health Council, 1993, p.1448). Not only does this benefit the people who progress, but it also makes services available for individuals who previously could not access needed services due to waiting lists and for those who have newly developed needs for public mental health assistance. The benefits of comprehensive mental health systems also directly affect the family members of persons with mental illness, who are often the primary caregivers in under-developed systems and who live with the frustration and failure of the system every day.

In addition to the direct economic and humane benefits discussed above, estimates are available on the indirect costs associated with inappropriate treatment and inadequate services for persons with severe mental illness (National Advisory Mental Health Council, 1993). These indirect costs include lost productivity and lost earnings due to illness (morbidity), due to premature death (mortality), and the costs of related service and support systems, including social welfare, criminal justice, and incarceration. Based on national estimates, providing a comprehensive service system for Milwaukee's adult citizens with mental illness would result in a return of approximately $78,125 each year to the county economy in the form of earnings as a result of reduced mortality. In terms of increased productive capacity, it is estimated that the annual average wage loss per person with a severe mental illness is $6,442; as such, if only 10% of persons in Milwaukee County receiving appropriate services from Milwaukee County returned to part-time employment (.5 FTE) each year, it would result in an increase of $3,607,520 each year in the county economy due to wages. Reductions in social welfare, criminal justice system, and incarceration costs can also be estimated at a total of $195,300 in savings. The above total to a net savings in indirect costs of approximately $3,880,950 each year. In addition, it is estimated that comprehensive mental health services result in a 10% reduction in general health care costs; as such, FY92 tax levy and health care plan dollars supporting general health care costs for persons with mental illness could potentially be saved.

Comprehensive, effective mental health service systems also create indirect cost savings in terms of increased staff morale and productivity and decreased staff turnover, due to working within a system that assists people to improve and regain their personhood, rather than one that is can only respond to people in crisis and reinforces clienthood (Curtis, McCabe, Fleming, and Carling, 1993).

In sum, this plan outlines a service system that will provide direct and indirect humane and

economic benefits to adults with mental illness, their family members, mental health workforce, and the taxpaying citizens of Milwaukee County.

OTHER FISCAL ISSUES

There are several broader fiscal issues which also need to be addressed within Milwaukee County and within the State of Wisconsin. Lack of Medicaid coverage for pre-crisis and crisis (exchanging non face-to-face telephone services) is a problem throughout the state of Wisconsin. Although all of the services recommended in this Plan can be implemented under the existing Medicaid funding regulations, the Wisconsin mental health service system is missing an opportunity to access more federal revenues to facilitate implementation of services such as those contained in the Milwaukee County Mental Health Master Plan. The current State Plan covers only certain on-site clinic services on a fairly restrictive basis. There could be much more comprehensive coverage (including mobile capacity) of assessment and crisis intervention / stabilization services in order to allow programs that promote these services to become more financially viable.

Milwaukee County and other local mental health authorities should work together with the State Mental Health and Medicaid agencies to consider strategies to expand coverage for these and other important services. Traditionally, such strategies would include state plan amendments for these services, and possibly mechanisms to use already allocated state and local funds or FFP match, as is done for CSP and Targeted Case Management Services. The current era, however, does not call for traditional strategies and solutions. National Health Care Reform will almost certainly result in a capping of Medicaid and the adoption of managed care methods to constrain a growth in costs. A number of states (Tennessee and others) are beginning now to implement broad-based waiver programs at an early enough point to allow the state to shape its own managed care strategies before possibly home restrictive and financially less favorable methods are put in place. The Health Care Financing Administration has recently demonstrated a much greater willingness, than in the past, to work with states on demonstration and other types of waivers that permit greater flexibility in service coverage in exchange for limitations in growth of federal outlays for services. If Milwaukee County and the rest of Wisconsin's mental health system consider that service coverage needs to be more flexible and comprehensive, it may be best to work with the State Medicaid Agency and other segments of Wisconsin's health care system as part of a broader-based health care reform initiative.

It should also be noted that Health Care Reform raises the prospect of public mental health agencies functioning in a managed care environment, where access / point of entry screening, assessment, crisis, and diversion service capacities are essential. Milwaukee County must have these capacities in place in order to function effectively in a managed care environment. Furthermore, the recommendations regarding clear target population definitions, using a RFP process for all services, and performance contracting with all providers could allow the Division to develop a capitation initiative for people with the most

severe needs. In capitation systems, all funds are consolidated in one pool and a predetermined amount is allocated to providers who contract to meet all the needs and achieve desired outcomes for specific groups of individuals (i.e., long stay inpatient residents). In capitated systems, the provider is responsible for effective utilization of the allocated resources across all individuals for all services needed by each person (including community and inpatient services), thus encouraging more proactive service provision to prevent the need for more intensive, costly reactive services.

Another area which needs attention is reimbursement for Clozaril. In the past three years, this new medication has been found to be effective in nearly one-third of patients with long-term schizophrenia who were previously unresponsive to all treatments. However, it is very expensive and it has side effects that require close monitoring. There are few funds available to provide reimbursement for this very expensive, but potentially extremely cost effective, medication. In recognition of this, the State of Wisconsin has developed a special appropriation for Clozaril for patients at the two State Institutions. This funding is not available to individuals at the Milwaukee County Mental Hospital, however. Therefore, the State Bureau of Mental Health and the Milwaukee County Department of Human Service should begin immediately to explore mechanisms to allow MHC patients to receive the special appropriation for Clozaril that is available to state institute patients.

In sum, this Master Plan should be used as a vehicle to begin a budgeting process linked to long-range planning. This requires that multi-year budgets be developed, based on existing and future service needs, and anchored by MIS data. In order to assure adequate revenue allocation, this multi-year budgeting process must be established in a collaborative process with the Department of Administration and the County Executive. In addition, it is crucial that DHS secure County Board support to retain within the mental health system any county-controlled revenues that might result from downsizing inpatient services, so that they may be used to develop the community-based services outlined in this plan.

CONCLUSION

The successful implementation of this Master Plan for the Public Sector Mental Health Service System for adults in Milwaukee County cannot occur without the full support of all constituencies, strong leadership from the Department of Human Services, and a commitment by the County Executive and County Board of Supervisors to the fiscal and programmatic directions within the plan.

The recommendations of inpatient downsizing, community service enhancement, and creation of a single point of authority must be implemented *simultaneously*; to implement only one or two of these elements would drastically undermine the integrity of the plan, and would continue the current fragmented service system in which individuals cannot receive responsive and effective services to meet their needs in a proactive rather than reactive way. The projected savings to Milwaukee County are a result of creating a seamless service system that will have positive benefits for each person needing services in terms of quality of life, and that will ultimately benefit the taxpayers of Milwaukee County in terms of decreased mental health service direct cost escalation, and decreased indirect costs to society due to mortality, morbidity, adjunct social welfare services, and family caregiving expenditures associated with severe mental illness when effective services ar not available.

As with any plan, this one should not be considered as an end product, but rather as laying the foundation on which future decisions should be made. The specifics within this plan *should change* as implementation gets under way, as the service system learns what variations are most appropriate to achieve its goals. What *should not change*, however, is that all decisions within the County about public sector services for adults with mental illness should adhere to, and be made in the context of, the Vision, Mission and Guiding Principles for the County of Milwaukee mental health system that were conceived and adopted by the Advisory Committee during the development of this plan. These should be considered the conscience of the system, and the rights of all adults within the county who need or desire to access public sector mental health services.

The recommendations of this Master Plan offer a threefold opportunity to community and inpatient workers, consumers, family members, advocates, and other stakeholders in the County of Milwaukee: first, to adapt the principles and implementation strategies of best practices existing in Milwaukee County and other communities for service delivery; secondly, to develop administrative and structural supports to enable the successful functioning of a comprehensive, responsive service system; and thirdly, to encourage and reinforce attitudes and values reflected in best practices in Milwaukee County and elsewhere: a mental health system which is oriented around achieving positive consumer outcomes rather than on maintaining existing programmatic and organizational structures.

INTRODUCTION

This Master Plan for Mental Health Services in Milwaukee County was developed through the Mental Health Master Plan Project commissioned by the Milwaukee County Department of Human Services and the County Board of Supervisors. The intent of the project was "to develop a comprehensive, long-range plan (5 years) for publicly funded mental health services in Milwaukee County...to guide Milwaukee County's resource allocation decisions so it provides the best mental health service system for adults in the County possible within the existing statutory requirements and funding limitations." As such, the project focused on all public sector mental health services provided for adults with mental illness throughout the county, including those provided by the Milwaukee County Mental Health Complex and those provided by private, non-profit agencies which contract with the Adult Services Division of the Department of Human Services.

This document represents the culmination of a variety of intensive activities to collect and analyze information about the mental health service delivery system in Milwaukee County. Project staff reviewed written and empirical information about community and inpatient services and finances, and conducted individual and group interviews with consumers, family members, advocates, services providers, administrators, and public officials throughout the county. In addition, a Master Plan Committee, comprised of representatives from key constituencies, advised the Master Plan Project. The Master Plan Committee held ten day-long meetings between April 7 and December 15, 1993 (see Appendix A). In total, nearly 300 individuals had direct input into the content of this Master Plan (see Appendix B).

The Master Plan is divided into two major sections:

Section One: The Existing Service System presents an overview of current mental health practices nationally and in Milwaukee County, and then provides an overview of the proposed comprehensive, integrated mental health system for Milwaukee County. This section of the Master Plan has three chapters:

> **Chapter One, The National Context,** reviews the historical development of mental health services in the United States and describes state-of-the-art practices.
>
> **Chapter Two, The Milwaukee County Context,** provides an overview of the Milwaukee County public mental health system, AND the current services provided, numbers of individuals served, and revenues for FY1992.
>
> **Chapter Three, Critical Issues Facing the Public Sector Mental Health System for Adults in Milwaukee County,** presents a summary of current system strengths and key issues that need to be addressed in order to have an effective service delivery system for the County's citizens with mental illness.

Section Two: The Proposed Service System presents recommendations for service and fiscal changes to implement a more effective and integrated service system in Milwaukee County.

Chapter Four, A Comprehensive, Integrated Mental Health Service System for Milwaukee County, presents the proposed changes in the service system to be developed over the next five years, based on the model service system developed by the Milwaukee County Master Plan Advisory Committee. This Chapter presents the Vision, Mission and Service Delivery Principles for the proposed service system; overall benefits of The Plan; specific services to be provided for identified target populations; and, the administrative structure and supports needed for a high quality, comprehensive public mental health system in Milwaukee County.

Chapter Five, Fiscal Plan, presents the methodology and assumptions used to conduct the fiscal analyses; outlines recommendations for funding shifts for the five year period to achieve the proposed service system within each of the five years; and highlights several broader fiscal issues that need to be addressed within the County and State context.

SECTION ONE

THE EXISTING SERVICE SYSTEM

CHAPTER ONE:

THE NATIONAL CONTEXT

HISTORICAL OVERVIEW

Historically, mental health service delivery has been determined by the existing assumptions about the needs of people with mental illness. For example, until the last few decades it was assumed that most people with mental illness would never recover, and they therefore needed long-term institutional care. As such, public mental health hospitals have been the primary locus of treatment throughout most of this century.

During the mid-fifties to mid-sixties, the introduction of psychotropic medications, along with increasing economic, legal, and ethical incentives to reduce institutional size resulted in people with mental illness beginning to live in community settings (Bachrach, 1983; Bell, 1980). Hospitals now had a dual role of providing both long-term and acute care, a situation which resulted in major changes in hospital treatment and functioning. Due to court-mandated changes for higher quality care, unionization, and laws protecting patients from work exploitation, public mental health hospital costs increased, although resident population decreased (Taube & Goldman, 1989).

At the same time, community mental health services were being developed as a result of federal policy initiatives and fueled by the new human rights movement. The explicit goal of community treatment was to keep people out of hospital settings, and recidivism was the primary measure of system effectiveness. Community treatment was conceptualized as a separate, competing service system, designed to demonstrate that community services were better than institutional care. Very little was known about the community service needs of people with mental illness, however, and community mental health funding was grossly inadequate for agencies to meet all the needs they were designed to address. As a result, without adequate resources, support services or follow-up, many people did not fare well, a situation which fueled an on-going debate about the "failure of deinstitutionalization" and the appropriateness of community living (Bachrach, 1982; Talbott, 1981; Turner & TenHoor, 1978).

As more people lived in the community for longer periods of time, however, expectations about the abilities of people with mental illness began to change, and the mental health field began to learn more about what services were needed to assist people to remain in the community (Bachrach, 1986; Turner & TenHoor, 1978). The mental health community began to shift from a view of mental illness as either acute or chronic (i.e., people will either get well or will need custodial care forever), to one in which every person was seen as having potential for overcoming the negative effects of the disability if given appropriate

supports (Anthony & Farkas, 1982; Estroff, 1987; NASMHPD, 1984). This shift was enhanced by the newly developing consumer and family advocacy movements which were beginning to speak out about their needs and demand more responsive and effective services.

Based on these changing assumptions about people with mental illness, community-based services began to focus both on keeping people out of hospital settings, and on enhancing their abilities; the goal was no longer community maintenance, but one of client growth. The development of the National Institute for Mental Health (NIMH) Community Support Program (CSP) in 1977 responded to this shift in thinking about the capabilities of people with mental illness and the role of community-based services. Designed to help localities develop more comprehensive community-based service systems, the CSP model stresses "the potential of these people and builds on their strengths and abilities by providing opportunities for rehabilitation and growth" (Brown 1989). The CSP service approach outlined core service components that should be available to "wrap" around a person to assist them to live in the community, and NIMH began funding initiatives to assist states to implement these core services (Stroul, 1989; Brown, 1989). As a result, the CSP model has been adopted by virtually all state mental health authorities, and their local counterparts, as their preferred services approach (NASMHPD, 1984).

Although inpatient services, including acute care and extended care services, is one of the core components of the CSP model, the division between institutional and community-based services has continued to exist. Rather than develop as an integrated service system, the historical dichotomy between these service components has been enhanced due to competition for limited resources and lack of clarity about the role of institutional care. As stated by Taube and Goldman (1989), "what developed is a large, complex system of services, funded by many different payers. What is needed is a system of integrated services for patients and clients with multiple needs... The role of the hospital within the total system of public mental health services has been the central policy question for more than 150 years. As the locus of care and responsibility shifts from the hospital to the community, the changes in policy ought to be guided by what we have learned from some of the innovations in the field." (p. 147).

NEW LEARNINGS

Since the introduction of CSP, knowledge about the capabilities and needs of people with severe and persistent psychiatric disabilities has changed tremendously. This increased knowledge has resulted from the practical experiences gained through actually trying to support people in the community who previously were or would have been institutionalized, from the increasing willingness of clients and their family members to speak out about their abilities and needs, and from the various learnings gained through research about the impact of services. Some of the more relevant learnings can be summarized as follows:

- Mental illness is not necessarily a life-long, degenerative process that progresses in a predictable, linear pattern (Brooks, 1988; Gardos, Cole, & LaBrie, 1982; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a,b; Morrison & Bellack, 1987; Rogers, 1987). For example, Harding et al. (1987b), in a twenty year follow-up of severely disabled hospital patients, found that "widely heterogeneous patterns of social, occupational and psychological functioning evolved over time" (p. 732), and they concurred with Vaillant (1978) that "diagnosis and prognosis should be treated as different dimensions" (p. 733).

- Many people with severe mental illness and emotional disturbance can maintain jobs, educational experiences, friends and families regardless of the presence of psychiatric symptoms and with various levels of mental health support (Anthony, Cohen, & Vitalo, 1978; Bond et al., 1988; Harding, 1986).

- Mental health services must be designed to be flexible and responsive to different individuals' needs within any given context (Carling, Randolph, Blanch & Ridgway, 1987; Minkoff, 1987; O'Brien, 1981; Turner & Shifren, 1979).

- People with mental illness can and should have a voice about the types and intensity of services that are offered within our mental health systems, and about the services they receive as individuals (Minkoff, 1987; Solomon, Gordon, & Davis, 1986; Strauss, 1986; Tanzman, 1991).

- Most people with mental illness do not define themselves as chronic mental patients, and they value independence and productivity more highly than any other treatment outcome or aspect of life (Chamberlin, 1978; Estroff & Patrick, 1987; Minkoff, 1987; Solomon, Gordon & Davis, 1986).

IMPLICATIONS FOR SERVICE DELIVERY

As a result of these new learnings, the mental health field is currently undergoing a "paradigm shift" from viewing people with severe mental illness as having to rely totally on the mental health system to meet all of their support and service needs, to one in which mental health consumers are seen as individuals like everyone else who rely on a variety of resources to meet their support needs, including informal caring networks, self-help groups, community groups and agencies, and the formal mental health system. The goal is now to develop comprehensive, integrated mental health service delivery systems that respect these new learnings and that will assist individuals with severe mental illness to achieve their desired life outcomes (Carling, in press; Wilson, 1988).

Such a comprehensive service system can be conceptualized as having five major focuses:

Risk Reduction	+	Wellness / Rehabilitation	←	Pre-Crisis Services	←	Crisis Response & Stabilization	←	Inpatient Services

In a well functioning system serving people who have been diagnosed with mental illness, as many resources as possible are dedicated to providing the services which focus on maintaining wellness, rehabilitation and pre-crisis intervention. In essence, these services serve a preventative function in that they assist people to maintain their normal routines and networks, and to achieve their desired goals. Once crisis response, stabilization, and inpatient services are needed, the individual often requires much more intensive, costly interventions, and their normal support networks and routines can be severely disrupted. As such, it is much more cost effective in the long-run to focus resources on services that prevent or divert such disruptive and costly care. In addition, even though it is still unknown how to prevent the initial onset of mental illness, recent advances have been made in the identification of risk factors which are associated with its occurrence. As such, progressive mental health systems dedicate resources for efforts which reduce these risk factors among the general population or identified at-risk groups.

Within this new approach to service delivery, a major challenge confronting public mental health service systems is how to assure the availability of these community mental health services within existing economic and work force constraints. Specifically, stakeholders are interested in how resources can be distributed and organized to serve as many persons as possible with high quality services and with highest priority directed to persons with the greatest need.

This challenge recognizes the interdependence of community and inpatient services. As well, this challenge confronts complex decisions required to achieve balance between hospital and community resources, accessibility to a full array of services, and sensitivity to the ethnic and cultural differences among service recipients. State, regional and local mental health systems are attempting to address this challenge through a variety of mechanisms (see Figure 1). However, the four essential and common components of these progressive service systems are: 1) the development of a clear statement of vision, mission and service delivery principles that is shared by all major constituents in the relevant geographical area, and that guides service system development and implementation; 2) clear identification of inpatient treatment roles and responsibilities within the overall system of care; 3) enhancement of community-based services; and 4) the development of administrative structures and supports to ensure that the service system functions in a way that achieves the vision, mission, and principles.

Figure 1

ORGANIZING COMPREHENSIVE MENTAL HEALTH SERVICE SYSTEMS

Many states and communities have developed coordinated, comprehensive mental health service systems that affirm consumer self-determination, promote normalization, and link consumers with peer and natural support systems. These systems have either progressed along the dimensions described below or implemented services and policies highlighted in the right column.

From	To
Reactive	Proactive
Focus on services and programs	Focus on people and environments
Fragmented or parallel inpatient and community funding as well as status quo regulations that thwart budget or staff transfers to under funded vital community services despite declining inpatient use	Funds follow consumers (in single stream funding), with consistent policies such as financial incentives for achieving positive service and system outcomes and / or disincentives for avoidable or unwarranted facility placements
Emphasis on fitting consumers' needs to existing programs and services	Enhanced community tenure and quality of life by molding services to needs and preferences of consumers / ex-patients
Predominance of office-based treatment, with consumers expected to come in for appointments	Out-of-office assistance with daily living and with entitlements, and networking and teaming with natural support systems
Formally organized and highly structured service delivery, with standards focusing on input (e.g., credentials) and process (e.g., treatment modes, prescriptive procedures)	Performance contracts for desired consumer, service, and system outcomes, with emphasis on agency and worker creativity in achieving effective, economical, and responsive results
Service planning and design by mental health agency staff and managers strongly influenced by traditional and / or existing funding streams, facilities, programs, and policies	Participatory planning, design, and development by consumers, family members, and other stakeholders in collaboration with managers and workers, and guided by least restrictive and most therapeutically appropriate and cost-effective values, policies, and practices
Staff engaging in discrete and occasional interventions in response to clients' requests	Teams and networks that orchestrate and nurture a blend of professional and natural support systems
Continuity of care promoted through coordination of a comprehensive service continuum anchored in inpatient settings and spanning intermediate and clinic treatment	Continuity of caregiver through Continuous Treatment and case Management Teams that have responsibility and authority to provide and / or access a wide array of community support and stabilization services

VALUES AND VISION

As shown in Figure 1, progressive mental health organizations emphasize consumer empowerment, normalization, and participatory decision-making through action with consumers, family members, inpatient, CMHC and other community staff, advocates, local governing bodies, legislators, and other stakeholders. These progressive systems have been developed based on the following tenets:

- Design and delivery of services should be guided by the needs and preferences of consumers and family members;
- At the heart of the mental health system, community-based services are therapeutically effective and are a viable alternative to inpatient care in most situations;
- Inpatient services must be integrated as a flexible back-up response to well-operating and comprehensive community-based services; the chief functions of inpatient care are rapid stabilization, and other assessment and intensive treatment that cannot be managed in the community;
- Most financial and human resources in public mental health systems should be allocated to community services, and dedicated to persons with serious mental illness;

and on the following guiding principles (Stroul, 1988, p. 6-7):

- Services should be consumer-centered;
- Services should empower clients;
- Services should be racially and culturally appropriate;
- Services should be flexible;
- Services should focus on strengths;
- Services should be normalized and incorporate natural supports;
- Services should meet special needs;
- Service systems should be accountable; and
- Services should be coordinated.

INPATIENT SERVICES

A crucial and challenging task in inpatient service system planning is for policy makers, managers, workers, and constituents to address several interdependent questions: 1) Who is, and who is not, to be served?; 2) What kinds and amounts of services will inpatient facilities provide?; and 3) How can utilization be reduced to the minimum needed?

Populations

A major trend in identifying who is or is not to be served is that central mental health authorities are developing policies and practices to prevent admissions and expedite discharges of persons whose mental health problems or mental illness do not warrant the intensity and / or restrictiveness of inpatient psychiatric care. Instead, they provide or arrange for viable community alternatives.

Essential Services

The kinds and amounts of services provided by public inpatient psychiatric facilities in consumer-focused and community-based mental health systems are rapidly changing. States, regions and counties have developed a variety of approaches to decrease the use of inpatient services. Many areas are limiting public inpatient admissions to services that, according to clinical judgement and available resources, cannot be provided at home or in community-based settings or general hospitals. For example, some systems have dedicated their inpatient resources to focus only on rapid stabilization, medical complications, specialized assessment or treatment, or public safety concerns that cannot be managed in comprehensive community support systems.

That is, an array of approaches are being developed for preventing or dealing with crisis situations that historically have resulted in hospital admissions. Model local and regional mental health systems operate comprehensive community support systems which include crisis prevention components, crisis response services, and alternatives to inpatient treatment, with inpatient treatment utilized if these other components are not appropriate or sufficient.

This back-up role of publicly operated inpatient treatment reflects two national trends. First, therapeutically valuable activities and functions that inpatient facilities have historically provided are now being "unbundled" and "rebundled" in community support systems. Specifically, such functions as crisis stabilization, respite, medical stabilization and supervision, clinical support, and therapeutic structure are being developed as activities that community support systems can offer in less restrictive settings. Second, consumers, family members, and community mental health workers are increasingly dedicated to providing all services in the least restrictive and most therapeutically appropriate and cost-effective

setting. This dedication is revealed through, on the one hand, a strong preference to avoid inpatient admissions whenever possible, and on the other hand, by creative and individualized arrangements that provide viable alternatives to inpatient services. However, public inpatient services have a vital contingency role as consumers, family members, and mental health workers continue to explore the boundaries of how much of the full array of services can be provided in a consumer-focused and community-based mental health system.

With the division of work and responsibility resulting from a refined understanding of inpatient treatment, inpatient and community staff are partners in achieving desired outcomes for service recipients. The essential goal of decentralizing and merging authority, responsibility, and accountability in local mental health systems is to achieve an integrated community and inpatient service system that is responsive to consumers. Former Director of the Ohio Department of Mental Health, Pamela Hyde, has framed the issue of service system decentralization in the context of inpatient and community integration:

> *I view the fundamental problem in mental health systems as a brick wall between the community mental health services and the hospital. We have put ladders against it, doors through it, and ropes over it. However, because of the structure of responsibility and funding, the brick wall divides the state and the community at the hospital door. When individuals come into the hospital, the state mental health authority is responsible; and we pay. When they leave the hospital, we are no longer responsible. When they are in the community, the community is responsible and pays partially; but when they are in the hospital, the community is no longer responsible. Responsibility for each side stops at the brick wall. We keep transferring legal responsibility to each other and placing it on the other side. As well, we keep shifting blame to the other side. The whole issue of decentralization is a change of funding and legal responsibility so the state can be more responsive to the community, we can move beyond blame placing, and together we can be more responsive to clients.*

Reducing Utilization

In their attempts to reduce use of publicly-funded facilities to only providing vital services, states and communities are pursuing a wide range of approaches to reduce the rate of psychiatric hospitalization. As noted above, the predominant method used throughout the country to reduce inpatient admissions is the provision of "upstream" crisis prevention and early intervention activities. The aim of these efforts is prevention of relapse through increased supports and intervention upon early evidence of potential decompensation. Sharfstein (1985) has noted: "The ability to help patients during an incipient stage of psychotic relapse may be the single most cost-effective intervention in this era of prospective payment."

However, it is a fact that funding mechanisms strongly influence services. In many mental health systems, inpatient utilization rates and levels are high, and most of the dollars are needed to support the high level of inpatient care. Often, these systems have a bifurcated funding structure. Inpatient services are budgeted separately from community programs, with the result that decreasing inpatient utilization does not release resources to communities. In such systems there are no mechanisms for "dollars to follow consumers" as their needs for service types and intensity change.

To address this issue, many model service systems are moving to an approach in which inpatient funding authority and responsibility are decentralized and merged with funding for community programs, with incentives to develop community alternatives to inpatient care, as well as disincentives to use inpatient care more than required. This creates a more balanced service delivery system, in that a majority of the resources are available for community-based services which serve a majority of the persons in need. Figure 2 summarizes the implications of bifurcated and unified (or single stream) funding.

Other examples of methods for reducing inpatient utilization include:

- Establishing a "single portal of entry" to the public mental health system, and a defined gatekeeping process within local mental health systems for entry into publicly funded inpatient services. The organizational entity for portal of entry and gatekeeping functions in many areas is through community mental health centers (CMHCs), or other community support or core service agencies.

- "Establishing special pre-admission screening and crisis stabilization units to prevent inappropriate admissions, identifying reasons behind large variability among counties' inpatient utilization, and determining reasonable utilization rates for each county" (Stockdill, 1990);

- Developing designated receiving facilities and management of inpatient utilization through admission monitoring and review of discharge plans (Hanson, 1990);

- Implementing a new inpatient reimbursement rate methodology that creates financial incentives for general hospitals to treat individuals during the acute phase of illness (i.e., higher reimbursement during initial period of stay), and for outpatient programs to accept referrals of discharged persons (Blanch, 1990);

- Retraining and redeploying inpatient staff to provide community support services (Hyde, 1990);

- Reimbursing community providers for each patient day not used by residents from their service area as compared with patient day utilization from a baseline period (Lensmeyer, 1990).

Figure 2

CONSEQUENCES OF ALTERNATIVE FUNDING STRUCTURES

PREVALENT FUNDING STRUCTURE FOR PUBLIC MENTAL HEALTH SYSTEMS

Central Mental Health Authority

----> <35% Community Mental Health Service Systems

----> >65% Public Psychiatric Facilities

In bifurcated funding systems, the proportion of funds going to community mental health services is frequently less than 35% of the total mental health budget.

MERGING RESPONSIBILITY WITH FUNDING AUTHORITY

SO "DOLLARS FOLLOW CONSUMERS"

Central Mental Health Authority

----> 90-100%

Community mental health service systems with comprehensive Community Support Systems, which use a hierarchy of options

1 ----> Home-based crisis stabilization

2 ----> Crisis apartments or respite beds

3 ----> Crisis care homes

4 ----> General hospitals (med / surg; psych)

5 ----> Public psychiatric facilities

<20%

In single stream systems, the funding authority channels funds to community mental health services that have authority and responsibility for purchasing inpatient services or community alternatives. When the community mental health system develops a comprehensive Community Support System, utilizes a range of community crisis options, and rigorously gatekeeps all potential inpatient admissions, more than 80% of funds remain in the community mental health system (Goodrick, 1988a, 1988b; Stephens, 1991).

What is noteworthy is that some mental health systems have developed community-based options and other administrative mechanisms to the extent that they utilize less than five adult inpatient psychiatric beds (i.e., general hospital and state-operated inpatient facility) per 100,000 population, and expend less than 20% of all mental health resources for residents of the service area for inpatient psychiatric treatment (Kent County, Rhode Island, cited in Goodrick, 1988a; Dane County, Wisconsin, cited in Goodrick, 1988b; and Northern Rhode Island Community Mental Health Center, cited in Stephens, 1991).

In conclusion, states and communities are attempting to restructure mental health services in ways that inpatient treatment has a vital yet refined, integrated, and contingent function. These values are being operationalized not only through efforts to improve relations between inpatient and community services, but also by implementing a variety of initiatives for reducing institutional admissions, utilization, and capacity. In addition, the savings created by reduction in inpatient utilization can be shared between inpatient and community service systems to enhance the service system as a whole.

COMMUNITY-BASED SERVICES

As noted above, a comprehensive service system can be conceptualized as having the following five key components:

Risk Reduction	+ Wellness / Rehabilitation	← Pre-Crisis Services	← Crisis Response & Stabilization	← Inpatient Services

With the obvious exception of inpatient services, all of these components can be addressed through services provided in community settings. States and communities throughout the country have developed a variety of programs and models to achieve these functions; however, research indicates that the most important part of service design is the focus on the service delivery principles listed on pages 6 and 7 and on achieving the desired outcome, rather than on a specific model for service delivery.

Risk Reduction

Unlike the other components on the above continuum, risk reduction activities are targeted toward promoting health and preventing problems within the community at large rather than providing treatment or services to individuals already experiencing a defined disability or illness. Although causation of mental illness is not yet clearly defined, several risk factors have been identified for these major disorders, including stressful life events, genetic pre-disposition, and low socioeconomic circumstances National Mental Health Association, 1986). In order to address these issues, mental health systems throughout the country have dedicated resources for prevention and risk reduction activities, such as training for mental health professionals about the concept

and impact of prevention efforts, establishment of mutual help groups, services for at-risk families, and skills and stress management training. For example, the Michigan Department of Mental Health supports the piloting, development and dissemination of prevention service models via the completion of manuals or guidelines that can be implemented through county mental health boards. Models have been completed on infant mental health services, parent education for low income parents of pre-school children, stress management training for low income women, school-based services for children of divorce, and services directed at the prevention of adolescent depression and suicide. As a result of this state-wide effort, a majority of Michigan's 55 county mental health boards have prevention services and / or planning projects.

Risk reduction activities can be implemented through a number of strategies. The role of mental health services is to train their workers to be knowledgeable about the importance of prevention and risk reduction, and methods for addressing these issues; ensuring that relevant programs are developed and implemented within the community; and, providing consultation to institutions that influence mental health, including schools, health agencies, hospitals, welfare agencies, other disability organizations, and so forth.

Wellness / Rehabilitation Services

The primary focus of a good mental health system should be to assist individuals with severe mental illness, as much as possible, to remain symptom-free and to achieve their life goals in the community. Many individuals with mental illness often lack self-confidence, due to stigma and the disabling effects of the symptoms and resulting treatments. In addition, their relationships with others may have been disrupted or strained over long periods of time, creating a sense of isolation, loneliness, and lack of social skills. Often, they may need assistance with basic activities of daily living, such as money-management, house-keeping, or leisure-time activities. Most are also poor, in that their education or vocations have been disrupted due to the occurrence of the mental illness, and payment for mental health treatment rapidly depletes any resources which the person might initially have. As such, they often need assistance with finding and maintaining adequate housing; buying food and clothing; educational, volunteer, skill training and job training and placement opportunities; and so forth. Additional core components of wellness maintenance are having access to counseling; medications and medication management assistance; good medical care; and peer support activities.

Effective service delivery systems have an array of services available which can meet each of these needs of individuals with mental illness. Core services include a focus on Housing, meaningful Daytime Activities, Counseling, Medication Management, Recreational / Social Activities, Peer Support and Advocacy, Health Management, and Income Management, if necessary. In addition to these individual service components, however, many systems now use case management as the primary mechanism for

ensuring that individuals receive the on-going assistance that they need from these services and resources.

Vermont's definition of case management, which draws on the successful experiences of numerous states, is: "Case management consists of actions based on the relationship between consumers and workers to access housing, educational, mental health, vocational, financial, medical, and other support services that consumers choose as necessary for successful community living" (Biss and Pierce, 1990). The purpose of case management is to achieve successful community integration through improved housing, improved employment and work status, increased network of friends, and decreased inpatient admissions treatment (Rapp and Poertner, 1989). Case management thereby becomes the core organizational unit for provision of most services to consumers.

Case managers engage in five essential actions:

1. Routinely provide services outside offices and in consumers' environments.

2. Creatively tailor services to meet each individual consumer's needs, and to help them achieve their own goals for housing, employment, and use of leisure time.

3. Assist consumers experiencing crises with flexible and responsive services, and reduce inappropriate inpatient treatment by providing whatever services or supports are necessary to prevent or resolve crises in clients' own housing.

4. Provide assertive outreach services.

5. Advocate to gain access to needed services or modify the service system.

Case management can either be delivered through an individual case manager or team case management approach.

Another service approach which has been effective in assisting individuals with more intensive service needs is the establishment of Continuous Treatment Teams. These teams work with highest priority clients, with sufficient staff so the team is always available, diverse in clinical skills, and protected from professional "burn-out" (New Hampshire, 1989). Families and significant others providing care to consumers also receive support from Continuous Treatment Teams.

More than continuity of care, Continuous Treatment Teams offer "continuity of caregiver" (Schroeder, 1990). Highlights from New Hampshire's approach to organizing and operating Continuous Treatment Teams offer valuable insights into organizing service systems.

- Continuous Treatment Teams usually consist of a nurse, master's level mental health professional, paraprofessional and consumer workers, and part-time psychiatrist available for consultation; the staff to client ratio is usually 1 to 8-12.

- Continuous Treatment Teams take complete clinical responsibility for a circumscribed group of clients regardless of the setting where clients are found. Continuous Treatment Teams relate to the client as a single entity (i.e., with uniform communications) and with the expectation that the client is a responsible citizen.

- Continuous Treatment Teams maintain a systemic and rehabilitative orientation towards clients, developing and using all community resources possible to meet the various needs clients may have. An important aspect of this concept is clinician access to all parts of the system [community, residential, and inpatient]. In their clinical activity, teams focus on community resources and attempt to prevent hospitalization. If hospitalization is necessary, Continuous Treatment Teams are involved in active treatment and / or treatment decisions.

- Individualized Service Plans are the clinical managing principle for the continuous treatment team. Plans are goal-specific, and include client participation.

- Teams are mobile, with positive inducements for being out of the office, and are assertive in their approach to meeting client needs. They 'meet clients where they are,' and do not expect them to spend their energies overcoming the [mental health or other health or human service] system's obstacles to service.

- Continuous Treatment Teams adopt the concept of an individual service envelope so they can respond to multiple needs: stress identification and management, psychosocial rehabilitation activities, and vocational initiatives.

- Teams are responsible for working with various parts of the community to maximize the environment for success. This means being supportive of individuals and organizations; providing education to the community; and clearly defining and accepting responsibility for clients' care.

Pre-Crisis Intervention

In addition to assisting individuals to maintain wellness, case management and continuous treatment teams also serve the function of recognizing when an individual may be developing either environmental or physical problems which might result in increased symptoms, and if not attended to, ultimately, the need for intensive crisis intervention services. In such cases, they often will increase the intensity of service to address the issue before it develop into a more serious situation.

Many systems also have developed other services, in addition to case management and continuous treatment teams, which focus pre-crisis intervention. The largest county in Vermont, for example, has an Assist Team, which is staffed by paraprofessionals with professional back-up, and can be called in for up to a week to stay with an individual in their own home while addressing the issues of concern. Warmlines, staffed twenty-four hours a day by consumers who can talk for as long as needed, also have been developed in many communities throughout the country.

Respite is another key service in this area. There are a wide variety of models of respite. For example, many areas offer a respite apartment or house that consumers can access for short periods of time if they need to leave their current living environment in order to address the presenting problem. Some mental health systems are providing similar respite opportunities for primary care-givers, whether mental health staff, family members, friends, or other consumers. According to Schwartz (1988), two major causes for hospitalization are when "crisis residential alternatives are at or above capacity, and staff feel tired and overwhelmed."

Immediate Crisis Response and Stabilization

Complementing community support system efforts to prevent crises, as well as offer early intervention and pre-crisis intervention, crisis response services are becoming more mobile, individualized, flexible, and voluntary (Blanch, 1988). As a result, states are establishing crisis response systems whose services include:

1. Assertive mobile outreach to the site of the emergency;

2. Twenty-four hours-a-day, seven days-a-week emergency phone and face-to-face response;

3. Walk-in crisis response setting readily accessible to persons in distress, their families and friends, law enforcement, and other referral agencies.

The key to effective crisis response services is the ability to respond quickly, and to have access to other components of the system in order to refer individuals to needed services that they can access immediately.

In New Hampshire communities and in Philadelphia, Mobile Crisis Response services are the first line of psychiatric services provided by the Community Mental Health Centers. Mobile Crisis Response services are available twenty-four-hours-a-day, seven-days-a-week statewide. During normal office hours, crisis response staff are on duty to handle emergencies throughout the community, and emergency walk-in clients. After-hours coverage is via immediate telephone and face-to-face contact with trained mental health clinicians, with back-up response provided by on-call psychiatrists. Mobile Crisis

Response services have the capacity to be provided at community locations, away from an office or hospital emergency room. Emergency services staff work closely with local hospital emergency rooms, police departments, homeless shelters, and other organizations that may come in contact with persons experiencing psychiatric emergencies.

The purpose of crisis stabilization services are to provide timely, accurate assessments of the issues which have led to the crisis, good clinical diagnoses and evaluations, and opportunities for short-term interventions to divert the need for more intensive services, such as inpatient stays. The mode for delivery of crisis stabilization services can be conceptualized along two dimensions:

A. In-home stabilization:

   1) Family or friend support, with crisis response staff back-up;

   2) Crisis specialists providing ongoing monitoring and support, with crisis response staff back-up; and

   3) Crisis response staff support and supervision.

B. Community-based placements:

   1) Beds in mental health service agencies for providing and supervising rapid stabilization services;

   2) Alternative family care options; and

   3) Crisis stabilization beds in a residence or apartment.

   4) Twenty-four hour evaluation service (either in a stand-alone facility, associated with a general hospital in the community, or at the public inpatient facility), with community support staff involvement

Washington County, Vermont has shifted the focus of crisis stabilization services from screening for admissions to its state-operated inpatient facility, to "intervention on the spot to avert admissions whenever possible." Many admissions have been averted by providing intensive services twenty-four hours-a-day seven days-a-week in persons' homes. For example, one Washington County initiative, Home Intervention, deploys an entire team--psychiatrist, nurse, and specialized staff--to intervene with individuals identified by inpatient admission screeners as refusing all community-based crisis options and being in imminent danger of hospitalization. The team focuses exclusively on one person until the crisis is resolved to the point that a transfer can be made to community support services. Home Intervention has effectively provided crisis stabilization services with

90% of referrals who would otherwise have been committed to the state hospital (Biss, 1990). Vermont has also developed consumer-operated crisis support services, such as telephone "warm lines" (Pierce, 1990). Further, consumers serving as emergency outreach worker aides in Vermont have contributed to rapid de-escalation of crises and offered sufficient support to permit persons experiencing crises to successfully remain in their own homes.

ADMINISTRATIVE STRUCTURES AND SUPPORTS

The development of a clear statement of vision, mission and service delivery principles, which is shared by all major constituencies, is a vital component in any well functioning, comprehensive mental health system of care. These values should drive inpatient and community-based service planning and development. However, a single point of clinical, fiscal, and administrative responsibility for the care of people with severe mental illness necessary in any well-coordinated, comprehensive service system in order to ensure that the system adheres to these guidelines, and that it results in positive outcomes for the people it serves.

Single Point of Accountability and Authority

There are a number of ways through which local communities have assumed increased authority, responsibility, and accountability, including the designation of County Board as the responsible entity, or in communities without County governance, the designation of a major provider within each region as the central mental health authority for the geographical catchment area. This has also been the approach in many large urban cities where services are often fragmented and lacking in community-based options, such as the nine Robert Wood Johnson Program on Chronic Mental Illness demonstration sites (Cohen, 1990). Regardless of whether the designee is a board or an existing service agency, however, the goal is to have one locus that holds the authority and responsibility for the clinical, fiscal, and administrative functioning of the overall system.

According to Stockdill (1990), the existence of a single point of authority provides for:

- centralization of decision making, management, and coordination of all services in a defined geographic area;

- availability and coordination of a comprehensive array of mental health services;

- single stream funding from the State level and authority which allows the central mental health authority to allocate funds and human resources based on clinical and service needs. This authority must include the responsibility for the utilization of resources for inpatient services;

- central point of data collection on service utilization and outcomes of service users throughout the system (both inpatient and community-based services); and

- service accountability based on 1) fiscal competence, 2) evidence of program implementation, and 3) evaluation of outcomes related to a range of measures.

More specifically, the central authority is responsible for:

- on-going service system planning;
- redefining target populations for the system as a whole, or for individual providers;
- adding or expanding services;
- contracting for all services (both inpatient and community-based);
- administering a centralized management information system on outcomes and service utilization;
- evaluating service effectiveness; amending provider contracts based on evaluation and performance;
- interacting with local, state and federal funding agencies; and
- addressing other overall system needs, such as staff training, attention to cultural and ethnic diversity in the overall workforce and service delivery, mental health service coordination with other relevant service systems, consumer and family involvement in all aspects of the service system, issues concerning legal representation, and so forth.

The existence of this single point of responsibility is at the core of effective service delivery systems (Cohen, 1990; Stroul, 1988).

Performance Contracts

In some of the most pace-setting mental health service systems, local organizational entities are vested with authority, responsibility, and accountability through performance contracts that increase community funding as a result of reducing inpatient utilization (Goodrick and Schaff, 1988; Schaff and Goodrick, 1988). In general, performance contracts are negotiated between the central authority and local providers, and target activities designed to reduce inpatient utilization. These performance contracts offer financial incentives for achieving desired consumer and service system outcomes (e.g., enhancing consumers' quality of life, acquiring jobs and decent housing, increasing community tenure, and reducing inpatient admissions and lengths of stay). As a result of performance contracts, local mental health systems are able to further develop a comprehensive array of community alternatives to inpatient care for consumers who are "most in need," and to address gaps and weaknesses in case management and crisis response services.

Target Populations and Capitation Approaches

Increasingly mental health service systems are adapting capitated approaches to service financing and resource allocation. The purpose of these approaches is to specifically identify and count different sub-populations of people using publicly funded mental health services and attach varying funding levels to each sub-population for their services. Capitated systems assume that different costs are associated with serving different sub-populations. Resources are allocated by sub-populations of clients, rather than by programs. In addition, capitated funding approaches are used to systematically prioritize the use of public funds in mental health services by insuring that providers have the resources needed to serve people with the most severe disabilities. Finally, capitation systems can also be used to allocate in-patient bed days.

In a helpful review of "Strategies for Integrating Public Mental Health Services," Mechanic (1991) provides an incisive analysis of capitation approaches to public mental health service delivery:

> *Capitation funding offers more powerful incentives to move the service delivery system in new directions. Capitation has three specific features: all defined services for a specified time period are provided through an agreed-on prepayment; payment is tied to the care of a particular patient; and the provider, in accepting the capitation, agrees to be at risk for costs exceeding the capitation amount. Thus the provider has incentive to manage carefully and to avoid unnecessary expensive treatment such as inpatient care....*
>
> *Capitation approaches are intuitively appealing, particularly as an opportunity for building systems. If enough patients are included, the resource fund for developing new services can be substantial. Also, capitation provides a clear incentive for giving attention to targeted patients. But the complexity of capitation systems, the technical knowledge required, and the high start-up costs pose formidable barriers to wide-spread adoption. The possibilities for using capitation increase as stronger mental health authorities develop."*

Capitation systems require both a formalized assessment method for assigning clients to sub-populations or target groups, often called certification, and an auditing mechanism to insure that the certification is happening appropriately, usually referred to as an auditing mechanism. All certification methods are inherently flawed, however the rates of error can be minimized. For instance, when New Hampshire first started using capitation audits revealed a certification process which resulted in roughly 85% accuracy. Within a few years, this margin of error has been reduced to 5% and New Hampshire currently reports a 95% rate of accuracy in their certification process (personal communication, Tom Fox 9/9/93). The auditing process is critical to establishing the credibility of a certification process.

Various criteria are used by different systems to establish target or sub-populations. Typically these include: diagnosis, disability or functional impairment, duration of disability, service utilization history, and sometimes historical cost of service.

SUMMARY

This review of how states and local mental health systems are organizing service delivery offers a threefold opportunity to community and inpatient workers, consumers, family members, advocates, and other stakeholders in the county of Milwaukee: first, to adapt the principles and implementation strategies of best practices existing in Milwaukee County and other communities for service delivery; secondly, to develop administrative and structural supports to enable the successful functioning of a comprehensive, responsive service system; and thirdly, to encourage and reinforce attitudes and values reflected in best practices in Milwaukee County and elsewhere: a mental health system which is oriented around achieving positive consumer outcomes rather than on maintaining existing programmatic and organizational structures.

CHAPTER TWO:

THE MILWAUKEE COUNTY CONTEXT

INTRODUCTION

The County of Milwaukee is unique within Wisconsin. It is the only urban center in the state, with a total population in 1990 of 965,067, of which 712,741 were 18 years or older and approximately 24% (172,415) of those 18 and older are over the age of 60. The county, located on Lake Michigan's western shore, covers 242 square miles, and is comprised of 19 municipalities. The City of Milwaukee, which is the primary municipality in the County, has a total population of 629,554, making it the nation's 17th largest city. The population of Milwaukee County also is culturally diverse: 75% of the population is white, 20% of the population is African-American, 2% is Asian and Pacific Islander, 1% is American Indian, and 2% are of other races. In addition, 5% of the population is of Hispanic origin (which may be of any race). In Milwaukee City, however, only 63% of the population is of the white race. The median household income for the county in 1989 was $27,867, although this varies widely by municipality, ranging from $23,627 in Milwaukee City to $110,712 in River Hills village. As such, in order to be effective, public sector mental health services must address the needs of a very diverse, urban population.

This chapter presents information about the FY92 public mental health system for adults in Milwaukee County, and serves to provide the background for the identification of critical issues facing the system, as described in Chapter Three, and the recommendations concerning the service system proposed in Chapter Four.

ADMINISTRATIVE STRUCTURE OF THE PUBLIC SECTOR MENTAL HEALTH SYSTEM FOR ADULTS IN MILWAUKEE COUNTY

Wisconsin has a county-based mental health delivery system with state funding and supervision, as established by Chapter 51 of the Wisconsin Statutes, the Mental Health Act. The intent of Chapter 51 is "to assure the provision of a full range of treatment and rehabilitation services for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse ...which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care" (*S.51.001, Wisconsin Statutes).*

For all Wisconsin counties, Chapter 51 delegates to the County Board of Supervisors ultimate responsibility for provision of these services, through the (i) establishment of a specific unit of government responsible for these services; (ii) designation of a program director, who is appointed and supervised by the County Executive; and (iii) appointment of a community services board, to function as a policy-making body concerning the administration of services and programs. In Milwaukee County, the Adult Services Division of the Department of Human Services has been designated as the point of authority by the County Board of Supervisors for the planning and delivery of services for adults, ages 18 to 60, and the Department on Aging is responsible for the planning and service delivery for persons over the age of 60. The Combined Community Services Board (CCSB) is the mandated advisory body for the Adult Services Division regarding the principles governing the administration of programs serving all disability populations. The CCSB is chaired by a County Board Supervisor, and has no direct staff.

With regards to mental illness, the Adult Services Division is responsible for:

- **Meeting the service needs** of persons with mental illness by contracting for, or directly providing: collaborative and cooperative services with public health and other groups for prevention programs; comprehensive diagnostic and evaluation services; inpatient and outpatient care and treatment; related research and staff in-service training; and continuous planning, development and evaluation of programs and services.

- **Entering into contracts** for, or directly providing, these services.

- **Preparing a local plan** that inventories all existing resources, identifies new needed resources and services and has long-range and immediate-range goals and strategies for achieving them.

- **Preparing a budget** for the succeeding calendar year, incorporating the above elements.

- **Authorizing care** in a state, local or private facility through contractual agreement, with the exclusion of county-governed facilities.

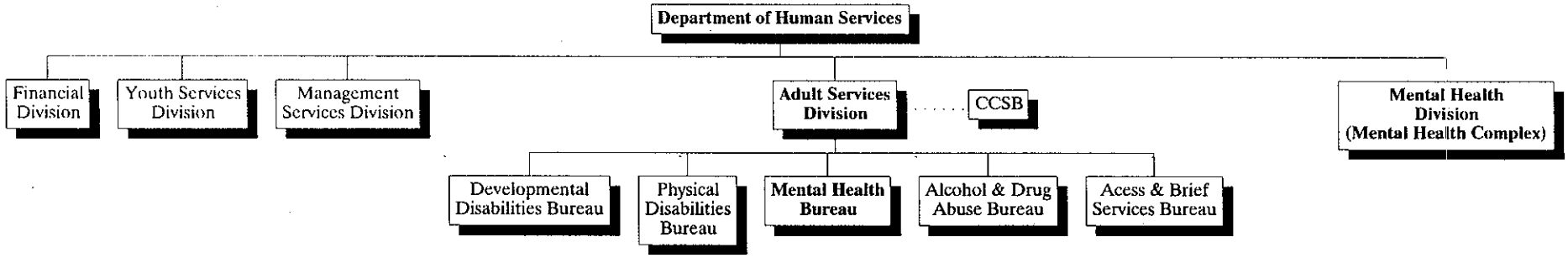
- **Allocating services** to reflect the availability of limited resources.

- **Evaluating** programs and services.

Functionally, public sector mental health services for adults with mental illness in Milwaukee County are primarily provided through two administrative structures within the Department of Human Services (DHS): the Mental Health Division and the Bureau of Mental Health within the Adult Services Division (see Figure 3).

Figure 3

1993 Organizational Structure
Department of Human Services



t:\ta\chart\org1a.cht

According to section 51.08, Wisconsin Statutes, a county having a population of 500,000 or more may establish a mental health complex which "shall be a hospital devoted to the detention and care of drug addicts, chronic patients, and mentally ill persons whose illness is acute." In addition to acute inpatient services (including services for individuals with geropsychiatric needs, alcohol and drug abuse problems, mental retardation and two units administered by Doyne Hospital (formerly Milwaukee County Medical Complex), MHC also provides long-term rehabilitation inpatient services and a variety of ambulatory services for adults (to be described in the section below), as well as inpatient, residential, outpatient and day treatment care for children and adolescents to age 18. In FY92, MHC had 1,644.5 FTE staff and annual revenues of $90,641,684, of which $65,857,963 was allocated to services for adults with mental illness. All staff of the Mental Health Complex are county employees.

The Bureau of Mental Health contracts with private agencies in the county to provide services to adults with mental illness in addition to those services provided by MHC. The Bureau also transfers community aids dollars to MHC to support some of its inpatient and ambulatory services; this fund transfer is conducted as a "pass through" rather than as a contractual arrangement. In addition to contracting for services, Bureau staff also conduct Watts reviews and Commitment Stipulations reviews, act as liaison for the county and state Community Support Program (CSP) initiative, and sit on the Community Residential Review Committee, which reviews persons referred for placement in community residential facilities. In FY92, the Bureau of Mental Health had 7.0 FTE staff and contracted with 24 provider agencies for services totaling $ 8,077,556, excluding the funds transferred to MHC. Organizationally, the Manger of the Mental Health Bureau reports to the Administrator of the Adult Services Division, who reports to the Director of the Department of Human Services (see Figure 5). The Combined Community Services Board, discussed previously, is advisory to the Adult Services Division.

It is important to note that the recent re-organizational efforts which created the Department of Human Services also created a new Department on Aging which has responsibility for all services for adults age 60 and older. As part of this separation of services responsibility, it was agreed that resources supporting Adult Service Division clients aged 60 and older as of January, 1994 would be transferred to the Department on Aging eventually. The implications of this agreement for the proposed adult mental health system in Milwaukee County is discussed in Chapters 3 and 5, and Appendix C contains The Department on Aging's Specialized Services Plan for People with Mental Health Needs.

The Mental Health Division of DHS is comprised of the county-operated Milwaukee County Mental Health Complex (MHC) (see Figure 4). Organizationally, the Administrator of MHC reports directly to the Director of the Department of Human Services.

Figure 4

1993 ORGANIZATIONAL STRUCTURE ADULT SERVICES DIVISION MENTAL HEALTH BUREAU

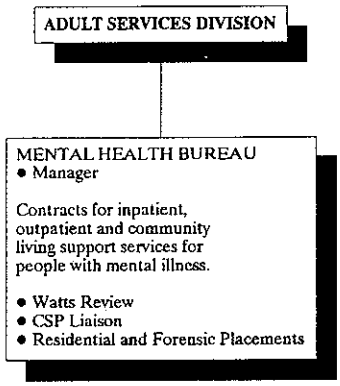
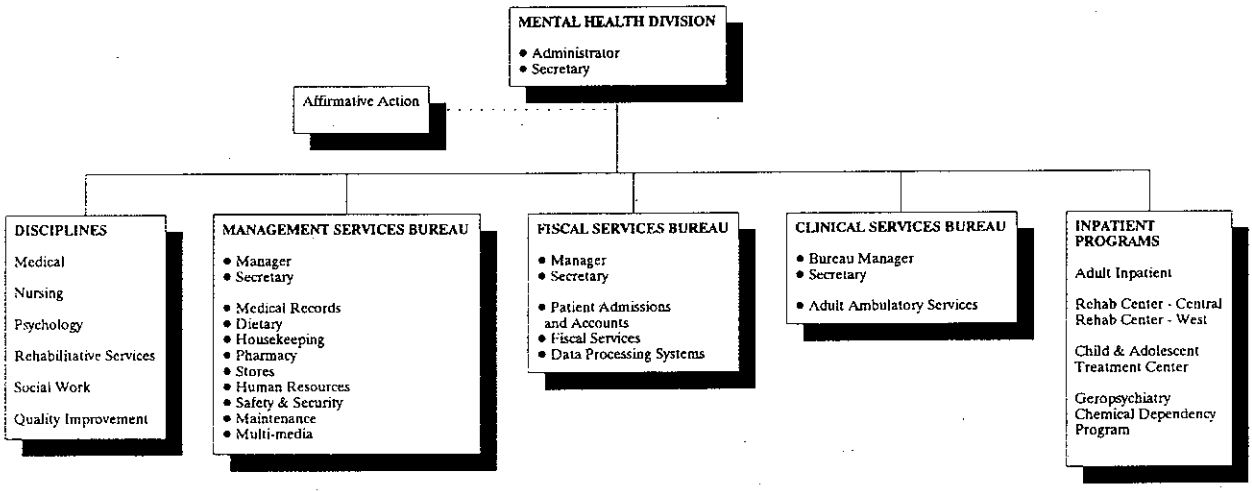


Figure 5

1993 ORGANIZATIONAL STRUCTURE MENTAL HEALTH DIVISION



ACCESS TO PUBLIC MENTAL HEALTH SERVICES FOR ADULTS IN MILWAUKEE COUNTY

VOLUNTARY SERVICES

Currently there are several ways to voluntarily request public mental health services in Milwaukee County. Individuals or family members can contact the Bureau of Mental Health or any of the provider agencies to request information about, or access to, specific services. Individuals can also walk into any of the outpatient clinics or emergency rooms in the general hospitals or Mental Health Complex to request public mental health services. In addition, every Wisconsin county is required to have a crisis intervention program and an emergency telephone number which is available 24 hours a day, seven days a week. In Milwaukee County, if someone in need of services calls this number, they are either referred to an existing service that is appropriate to their needs (if it is not a crisis situation) or the police are contacted to respond to the situation.

INVOLUNTARY TREATMENT

If a person with mental illness presents a danger to self or others, as defined by law, law enforcement officers are empowered to take that person into custody and transport the person to the detention facility (currently the Mental Health Complex) for assessment and evaluation. This is called an emergency detention. In Milwaukee County, the officer must submit a statement to the facility staff that states the facts which led the officer to believe that the person meets the civil commitment criteria, and the staff then have 24 hours to determine whether the person should be detained or released. If detainment seems appropriate, the staff must submit the emergency detention statement and any additional clinical information to the courts to petition for involuntary commitment. The person can be held for 72 hours until the "probable cause hearing" is held to determine whether the person meets the standards for civil commitment.

A civil commitment procedure can also be initiated by a three party petition. In this process, three adults must sign a petition requesting a civil commitment proceeding. At least one of the adults must have personal knowledge of the person's behavior and the other two must have factual reasons to believe that the person meets the civil commitment criteria.

The civil commitment procedure, as defined by Chapter 51, is a court-ordered mandate for persons who are mentally ill to receive treatment for his or her condition on an involuntary basis. Civil commitment is intended to assist people who are not aware of their need for treatment to receive services and improve their condition; it also is intended to protect the person and the public from dangerous behavior displayed by the person being committed.

In both of the situations for initiation of civil commitment proceedings (emergency detention or three party petition), legal representation is provided for the three-party petitioners or for the facility staff by the county Corporation Council, which handles all legal matters for the County. In instances where the Corporation Counsel does not believe there is enough evidence to justify civil commitment, Corporation Counsel may refuse to provide assistance in filing the petition or they may negotiate with the individual's legal representative to have the person access less restrictive treatment services (e.g. outpatient counseling).

There is much debate about the standards or criteria used to prove need for civil commitment. The *Lessard v. Schmidt* decision, which was promulgated into Wisconsin law in 1976, holds that a person must be dangerous to self or others to be committed, that rigorous procedures which focus on individual rights must be followed, and that treatment must be provided in the least restrictive setting appropriate for the person's needs. Although the intent of this ruling was to ensure more appropriate treatment for individuals when hospitalization is not absolutely necessary, the standards have come under attack for being too stringent by some constituencies in the state. These constituencies argue that people often get little or no treatment if they are not admitted to inpatient services through civil commitment procedures, since other services are not readily available. As such, a bill was introduced in the FY92 Legislative session to create a Fifth Standard, which would allow 30 day involuntary commitments for inpatient care (and involuntary medication) based on the need for treatment without meeting the dangerous requirement. (The commitment status would be in effect for six months and could be used for inpatient or outpatient commitment, although the inpatient commitments could only be in 30 day increments. Opponents of this bill argue that the "prevention of further deterioration" clause in the Fifth Standard is open to wide interpretation, and could drastically undermine individuals' rights. In addition, they note that the problem is not the need for involuntary inpatient services, but rather the lack of appropriate alternative treatment services in the community to address individual's needs.

In some instances, the criminal justice system is involved in access to mental health services. If a police officer is called to a location and there has been a suspected or known crime committed by someone who may have a mental illness, the officer can decide to either arrest the person or to enact an emergency detention. If the person is arrested and awaiting trial or serving a sentence after conviction, the person may receive voluntary mental health treatment in the jail or be transferred voluntarily to the Mental Health Complex (MHC) inpatient services. Involuntary transfer and commitments also can be made to the State Institutes or to MHC if the person meets the civil commitment criteria. In addition, individuals may be ordered to receive mental health treatment as a condition of bail or probation.

There are two other forms of forensic commitment which involve persons who are either determined incompetent to stand trial or who were found not guilty by reason of insanity. Although these two procedures are very complex, in general, individuals in these circumstances are committed for treatment until they are found competent to stand trial or, in the case of the insanity defense, until they are deemed no longer dangerous or the individual has served the maximum period of the sentence for the crime.

A final form of involuntary mental health treatment is that provided by protective placements. This is a court-ordered process which results in placement in a long-term care facility, and is only used for individuals who are found legally incompetent to make decisions regarding their care or finances. In these cases, the court appoints a legal guardian who is authorized to make decisions for the person. If long-term residential placement is felt appropriate, the guardian petitions the court to begin a protective placement process.

Patient rights are also defined in the state statutes, including the right to prompt and adequate treatment, the right to the least restrictive conditions required to achieve the purposes of treatment, and the right to refuse medication and treatment, unless an emergency situation or if a court hearing determines the person is not competent to make a decision about medication and treatment. In addition, individuals whose rights have been violated can obtain legal representation through the Protection and Advocacy agency. In Milwaukee County, this service is provided through the Legal Aid Society of Milwaukee. People involved in commitment proceedings are represented by the Public Defender's Office, or in certain circumstances, by Legal Aid.

OVERVIEW OF FY92 PUBLIC SECTOR MENTAL HEALTH SERVICES FOR ADULTS IN MILWAUKEE COUNTY

Tables 1 and 2 present the array of public sector services provided to adults with mental illness in Milwaukee County in FY92, the numbers of unduplicated adults who received each of these services, and a summary of the revenue sources for these adult services.

TOTAL NUMBER OF ADULTS SERVED

There is no management information system in Milwaukee County across the adult mental health provider agencies or that interfaces with the Mental Health Complex; as such, it is not possible to know how many unduplicated adults are served annually across all mental health programs in the County. In addition, the management information system which provides service utilization information to the Bureau of Mental Health does not allow unduplicated counts of individuals served across all programs provided by the contracted agencies, but only within each program area. A similar situation exists with the information system at the Mental Health Complex. As such, Table 1 presents separate unduplicated counts of adults served by each of the service components provided by the Mental Health Complex (MHC) and by each of the service components provided by the agencies contracting with the Adult Services Division, Bureau of Mental Health (ASD). For the reasons stated above, these numbers are not additive across MCMHC and ASD for each service, nor are they additive across all services provided by either ASD or MHC.

As can be seen in Table 1, the service components which served the most people were Outpatient Programs (1,322 by ASD agencies and 8,073 by MHC), the MHC Psychiatric Crisis Service (8,707), and MHC acute inpatient services (2,234). In total, 4,010 individuals were inpatients at MCMHC in FY92.

AVAILABLE SERVICES

The service components listed in Table 1 represent all mental health services provided for adults (over 18) by agencies which contracted with the Adult Services Division (ASD) and provided by the Milwaukee County Mental Health Complex (MCMHC) in FY92. Following is a descriptions of each service component, along with information about numbers served.

TABLE 1

MILWAUKEE COUNTY PUBLIC MENTAL HEALTH SERVICES FOR ADULTS

NUMBERS SERVED and REVENUE SOURCE TOTALS BY ORGANIZATION, FY92

SERVICE COMPONENT	UNDUP# SRVD ASD	UNDUP# SRVD MCMHC	TOTAL REVENUE SOURCES	REVENUE TOTALS BY ORGANIZATION ASD	AGENCY *	MCMHC
RISK REDUCTION SERVICES						
Family/Child Programs	NA	NA	$164,914	$56,694	$108,220	$0
Public MH Education/Referral	NA	NA	$103,462	$31,758	$71,704	$0
RISK REDUCTION SUBTOTAL:			$268,376	$88,452	$179,924	$0
% of Total MH Revenue Sources			0.33%			
WELLNESS/REHABILITATION						
CSPs						
Certified Independent Living	537	255	$2,843,712	$883,703	$312,582	$1,647,427
Non-Certified Independent Living (excl WCS)	104	0	$104,390	$91,942	$12,448	$0
Supported Apartment CSP: Certified	38	0	$87,134	$87,134	$0	$0
Supported Apartment CSP: Non-Certified	76	0	$414,603	$378,459	$36,144	$0
Geropsychiatry Triage Prgm	0	1,043	$734,900	$0	$0	$734,900
COP (Admin Staff)	0	293	$139,325	$0	$0	$139,325
Community Consultation Liaison Program	0	398	$140,006	$0	$0	$140,006
Benefits Coordination (Housing Follow-Along)	0	152	in MHC Outpt & Day Treatment	$0	$0	in MHC Outpt & Day Treatment
Housing						
Community Based Residential Facilities	245	0	$5,442,451	$3,217,437	$2,225,014	$0
Adult Family Care Home	24	0	$185,886	$106,171	$79,715	$0
Health Care						
Home Health Care	270	0		$0		$0
			$0	$0	$0	$0
Day Activities						
Work Programs	175	0	$554,905	$531,982	$22,923	$0
Community Employment	99	0	$315,244	$309,365	$5,879	$0
Psychosocial Clubs/Drop-in Centers	195	0	$280,065	$204,469	$75,596	$0
Day Treatment	428	511	$4,056,867	$498,243	$1,137,154	$2,421,470
Consumer Support/Education/Advocacy						
Families	400	0	$29,720	$29,720	$0	$0
Income Management						
Protect Payeeships	25	0	$42,353	$14,193	$28,160	$0
Protect Payeeships	33	0	in Family Support	in Family Support		
Guardianships	17	0	$22,800	$22,800	$0	$0
Outpatient Counseling/Medication Help (incl Homeless Mobile Community Clinic)	1,322	8,073	$9,069,108	$264,139	$2,050,720	$6,754,249
Alternative Counseling		500	$158,410	$44,261	$114,149	$0
WELLNESS SUBTOTAL			$24,621,879	$6,684,018	$6,100,484	$11,837,377
% of Total MH Revenue Sources			31%			
PRE-CRISIS SERVICES						
Homeless Services						
Mobile Community Clinic	In MHC Outpt		$0			
Health Care	468	0	$268,297	$181,015	$87,282	$0
Jail/Forensic Services						
Non-Certified: CSP	228	0	$786,978	$579,124	$207,854	$0
Jail Diversion	1,000	0	$15,274	$15,274	$0	$0
Evaluation/Treatment: House of Correction	240	0	$109,180	$109,180	$0	$0
Forensic Outpatient Evaluation Services	0	695	$444,078	$0	$0	$444,078
Substance Abuse Counseling	0	727	$322,847	$0	$0	$322,847
PRE-CRISIS SUBTOTAL			$1,946,654	$884,593	$295,136	$766,925
% of Total MH Revenue Sources			2%			
CRISIS RESPONSE/STABILIZATION SERVICES						
Hotline/Crisis Line	0	in PCS	$0	$0	$0	in PCS
Psychiatric Crisis Service (PCS)	0	8,707	$4,477,318	$0	$0	$4,477,318
CRISIS RESPONSE/STABILIZATION SUBTOTAL			$4,477,318	$0	$0	$4,477,318
% of Total MH Revenue Sources			6%			
TOTAL COMMUNITY REVENUES			$31,314,227	$7,657,063	$6,575,544	$17,081,620
INPATIENT SERVICES	Annual # Svd	Bed Capacity	TOTAL COST			
Acute: General	2,234	96	$16,495,429	$0	$0	$16,495,429
Acute: Geropsychiatry	in Acute	48	$0	$0	$0	$0
MCMC Medical Psych Units	739	48	$4,404,103	$0	$0	$4,404,103
Dual Diagnosis (MI/SA)	617	55	$4,813,178	$0	$0	$4,813,178
Rehabilitation	406	320	$23,063,633	$0	$0	$23,063,633
Westview Nursing Home	4	4	$56,861	$56,861	$0	$0
Wisconsin State Institutes	10	4	$363,632	$363,632	$0	$0
INPATIENT SUB-TOTAL	4,010	575	$49,196,836	$420,493	$0	$48,776,343
% of Total MH Revenue Sources			61%			
% Rehabilitation/Total Inpatient			47%			
TOTAL ADULT SYSTEM			$80,511,063	$8,077,556	$6,575,544	$65,857,963

TABLE 2

MILWAUKEE COUNTY PUBLIC MENTAL HEALTH SERVICES FOR ADULTS

REVENUE TOTALS BY SOURCE CATEGORIES

SERVICE COMPONENT	TOTAL REVENUE SOURCES	REVENUE TOTALS BY SOURCE: COMMUNITY AIDS	TAX LEVY	IMD	MC HEALTH CARE FINANCING PLAN	T-18 T-19	OTHER
RISK REDUCTION SERVICES							
Family/Child Programs	$164,914	$56,694	$0	$0	$0	$0	$108,220
Public MH Education/Referral	$103,462	$31,758	$0	$0	$0	$0	$71,704
RISK REDUCTION SUBTOTAL:	$268,376	$88,452	$0	$0	$0	$0	$179,924
% of Total MH Revenue Sources	0.33%						
WELLNESS/REHABILITATION							
CSPs							
Certified Independent Living	$2,843,712	$1,396,279	$27,424	$0	$15	$803,846	$616,148
Non-Certified Independent Living (excl WCS)	$104,390	$74,462	$17,480	$0	$0	$0	$12,448
Supported Apartment CSP: Certified	$87,134	$87,134	$0	$0	$0	$0	$0
Supported Apartment CSP: Non-Certified	$414,603	$325,755	$52,704	$0	$0	$0	$36,144
Geropsychiatry Triage Prgm	$734,900	$565,000	($3,415)	$0	$2,031	$150,692	$20,592
COP (Admin Staff)	$139,325	$39,611	($475,754)	$0	$0	$0	$575,468
Community Consultation Liaison Program	$140,006	$140,000	$6	$0	$0	$0	$0
Benefits Coordination (Housing Follow-Along)	in MHC Outpt & Day Treatment	$0	$0	$0	$0	$0	$0
Housing							
Community Based Residential Facilities	$5,442,451	$2,598,430	$146,287	$472,720	$0	$293,631	$1,931,383
Adult Family Care Home	$185,886	$106,171	$0	$0	$0	$0	$79,715
Health Care							
Home Health Care	$0	$0	$0	$0	$0	$0	$0
Day Activities							
Work Programs	$554,905	$524,542	$7,440	$0	$0	$0	$22,923
Community Employment	$315,244	$303,675	$5,690	$0	$0	$0	$5,879
Psychosocial Clubs/Drop-in Centers	$280,065	$204,469	$0	$0	$0	$0	$75,596
Day Treatment	$4,056,867	$1,742,369	($12,546)	$0	$127,100	$2,044,609	$155,335
Consumer Support/Education/Advocacy							
Families	$29,720	$29,720	$0	$0	$0	$0	$0
Income Management							
Protect Payeeships	$42,353	$14,193	$0	$0	$0	$12,000	$16,160
Protect Payeeships	in Family Support	$0	$0	$0	$0	$0	$0
Guardianships	$22,800	$22,800	$0	$0	$0	$0	$0
Outpatient Counseling/Medication Help (incl Homeless Mobile Community Clinic)	$9,069,108	$8,417,493	($4,135,425)	$0	$624,822	$2,797,671	$1,364,547
Alternative Counseling	$158,410	$44,261	$0	$0	$0	$0	$114,149
WELLNESS SUBTOTAL	$24,621,879	$16,636,364	($4,370,109)	$472,720	$753,968	$6,102,449	$5,026,487
% of Total MH Revenue Sources	31%						
PRE-CRISIS SERVICES							
Homeless Services							
Mobile Community Clinic	$0	$0	$0	$0	$0	$0	$0
Health Care	$268,297	$0	$0	$0	$0	$0	$268,297
Jail/Forensic Services							
Non-Certified: CSP	$786,978	$387,920	$8,740	$0	$0	$85,939	$304,379
Jail Diversion	$15,274	$15,274	$0	$0	$0	$0	$0
Evaluation/Treatment: House of Correction	$109,180	$109,180	$0	$0	$0	$0	$0
Forensic Outpatient Evaluation Service	$444,078	$344,758	$99,320	$0	$0	$0	$0
Substance Abuse Counseling	$322,847	$265,000	$5,395	$0	$19,048	$31,509	$1,895
PRE-CRISIS SUBTOTAL	$1,946,654	$1,122,132	$113,455	$0	$19,048	$117,448	$574,571
% of Total MH Revenue Sources	2%						
CRISIS RESPONSE/STABILIZATION SERVICES							
Hotline/Crisis Line	$0	$0	$0	$0	$0	$0	$0
Psychiatric Crisis Service (PCS)	$4,477,318	$3,500,000	$52,122	$0	$107,448	$468,010	$349,738
CRISIS RESPONSE/STABILIZATION SUBTOTAL	$4,477,318	$3,500,000	$52,122	$0	$107,448	$468,010	$349,738
% of Total MH Revenue Sources	6%						
INPATIENT SERVICES	TOTAL COST						
Acute: General	$16,495,429	$0	$1,699,368	$0	$5,263,387	$7,258,275	$2,274,399
Acute: Geropsychiatry	$0	$0	$0	$0	$0	$0	$0
MCMC Medical Psych Units	$4,404,103	$0	$873,306	$0	$0	$0	$3,530,797
Dual Diagnosis (MI/SA)	$4,813,178	$0	$1,890,040	$0	$2,320,600	$546,057	$56,481
Rehabilitation	$23,063,633	$386,688	$9,490,325	$7,012,505	$0	$5,277,350	$896,765
Westview Nursing Home	$56,861	$0	$0	$56,861	$0	$0	$0
Wisconsin State Institutes	$363,632	$292,594	$71,038	$0	$0	$0	$0
INPATIENT SUB-TOTAL	$49,196,836	$679,282	$14,024,077	$7,069,366	$7,583,987	$13,081,682	$6,758,442
% of Total MH Revenue Sources	61%						
% Rehabilitation/Total Inpatient	47%						
TOTAL ADULT PUBLIC SYSTEM	$80,511,063	$22,026,230	$9,819,545	$7,542,086	$8,464,451	$19,769,589	$12,889,162
% of Total Revenues		27%	12%	9%	11%	25%	16%

* Agency Payment Sources reflect revenue received by ASD-contracted agencies in addition to revenues received from ASD or MCMHC.

Note: Revenue Sources Based on FY92 Actuals, as reported by ASD and MCMHC

MCMHC client counts based on "MCMHC Unduplicated Count of Clients by Race and Program, 01/01/92 - 12/31/92"

Risk Reduction Services

In FY92, .33% of all revenues in the public sector mental health system were allocated to four organizations which specifically focus on risk reduction activities. One-third of these resources were provided to contract agencies by ASD, while the remaining two-thirds were generated by the agencies themselves. No mental Health Complex revenues were allocated for this type of activity. The activities provided by these four organizations included early intervention services to support high risk families, work-site wellness programs, coping skills education, suicide and depression prevention programs, and education and information directed towards the general public about mental health issues, symptoms, and service resources.

Wellness / Rehabilitation Services

Community Support Programs (CSPs)

CSPs are a standardized set of services, promulgated under Chapter 51, that are designed to provide intensive case management and mobile treatment, rehabilitation, and support services to individuals with severe mental illness. CSPs are based on a case management system which combines advocacy, coordination, system planning, monitoring and support functions. Each CSP client has a designated case manager that is responsible for maintaining a clinical relationship with the client on a continuing basis whether the client is in the hospital, in the community, or involved with other agencies (Wisconsin Administrative Code, HSS 63.12). CSPs are required to provide or make arrangements for access to, a comprehensive system of services, including symptom management or supportive (family, group or individual) psychotherapy; psychiatric and psychological services; medication prescription, administration, monitoring and documentation; crisis intervention services; employment related services; social and recreational skills training; activities of daily living support and training; physical health services; legal services; transportation services; benefits access and coordination; and safe and normal housing (HSS 63.11).

Each Community Support Program must have on its staff a director, a psychiatrist and a clinical coordinator, who provides direct supervision of CSP clinical staff. In addition, CSP clinical staff may include CSP professionals (who have a bachelor's degree), licensed clinical psychologists, clinical social workers with a MSW, registered nurses, occupational and recreational therapists, certified rehabilitation counselors, vocational counselors, and paraprofessional mental health technicians (HSS 63.06). The maximum staff to client ratio is 1:20, and at least 50% of service contacts must be provided in the community in non-office based or non-facility based settings. The eligibility criteria for access to CSP services is very stringent, with a focus on individuals with the most severe needs.

Within Milwaukee County, there are two types of CSP programs: Independent Living and Supported Apartment CSPs. These types of CSPs primarily differ in terms of intensity of support available to individuals, with supported apartment CSPs having staff to client ratios that allow more intensive levels of support. There also are two different categories of CSPs, certified and non-certified, which primarily reflects whether the programs meet the criteria set forth by Chapter 51. State reimbursement for CSPs differs based on this certification status.

In FY92, a total of 1,238 adults were served by 12 Community Support Programs in Milwaukee County. Of these twelve CSPs, nine were operated by seven ASD contracted agencies, while three were operated by MHC. A total of 830 people were served by six certified programs, and 408 people were served by six non-certified programs. One of these non-certified CSPs is a program which assisted 228 people in FY92 who were involved in criminal proceedings. Because of the focus of this CSP, it is listed on Tables 1 and 2 under Jail / Forensic services within the Pre-crisis Service category.

Geropsychiatry Triage Program

The Geropsychiatry Triage Program is operated by MHC to provide a comprehensive system of diagnostic, treatment, and referral services to people who are elderly who have mental disorders, with the primary intent of keeping an individual in the community whenever possible. The program is staffed by a multi-faceted team of psychiatrists, nurses and social workers who have specific expertise in geropsychiatric issues. This program served 1,043 individuals in FY92.

Community Options Program (COP)

This statewide funding program assists people with severe mental illness who live at the Institute for Mental Disease / nursing homes or are at risk of entering such facilities, who generally do not have support systems, are receiving limited financial assistance, and are unable to access community resources for a variety of reasons. COP provides long-term support to enable them to live at home or in community-integrated settings and to have ready access to generic community resources, such as shopping, money management, and medications monitoring. This program operates out of MHC, and in FY92, COP served 293 individuals.

Community Consultation Liaison Program (CCLP)

This is a mobile service which responds to unmet community-based needs for on-site mental health assessments, short-term interventions, triage to on-going services and programs, and follow-up assessment. Because there are no outreach crisis services

available in Milwaukee County, CCLP responds to a variety of situations in which there is a need for community-based assessments and triage, including those that involve persons who are in immediate crisis due to a severe mental illness, and those that involve persons who need assessment and triage but are not in immediate crisis. Operated by MHC, it is staffed by two full-time registered nurses, and is available from 8 am to 5 pm, Monday through Friday. In FY92, CCLP provided these services to 398 individuals.

Benefits Coordination / Housing Follow-Along

This service is operated by MHC to help coordinate access to living arrangements and eligible public assistance benefits prior to discharge from inpatient services. This program served 152 people in FY92.

Housing

In FY92, there were two types of structured, non-hospital-based residential services for adults with mental illness. The Adult Services Division contracted with five provider agencies to operate sixteen Community-Based Residential Facilities (CBRFs) which served 245 people, and one provider agency to operate an Adult Family Care Home Program which served 24 people. CBRFs are residential treatment programs, staffed 16 hours a day, which provide a structured living environment and services to enable the person to function more independently and / or transition to a less restrictive community setting. CBRF services include supervision, dietary counseling, medication monitoring, financial management, social activities, and vocational guidance. The Adult Family Care Home program places people in family homes and provides case management and support for the family caring for the individual.

Home Health Care

Although not funded by ASD or MHC, in-home nursing visits were provided to 585 individuals with a primary diagnosis of mental illness by one identified home health care agency in Milwaukee County in FY92. The types of services provided during these visits include physical health problem management, medication management, hygiene assistance, disease process management / therapeutic intervention, diet / nutrition counseling, service coordination, risk factor management, and skills teaching.

Daytime Activities

Work Programs: These services provide paid work in rehabilitation facilities to assist individuals in understanding the meaning, value and demands of work, modify work behavior, and provide vocational development. In FY92, ASD contracted with three agencies which provided this service to a total of 175 individuals.

Community Employment: These services are targeted to individuals who desire competitive employment, and consists of a range of services to help the person secure community employment and provide support and supervision at the job site to help assure job retention. In FY92, ASD contracted with three agencies to provide these services for 99 individuals.

Psychosocial Rehabilitation Clubhouse Programs: ASD provided funds to one psychosocial rehabilitation club in FY92. This organization, which had at least 195 members, is designed to provide social and recreational opportunities and encourage self-worth, initiative and responsibility as related to social and vocational skill development. It is a Fountain House model clubhouse dedicated to returning mental health consumers to work.

ASD also provided resources to support a consumer drop-in center, which is open weekday afternoons, and is a social and activity center run by and for mental health consumers.

Therapeutic Day Treatment: These services consist of a medically supervised day program in a structured environment to assist a person to return to his / her previous level of functioning. It provides case management, medical care, psychotherapy and other therapies, with a primary emphasis on addressing symptoms or functional issues which prohibit the person from engaging in less restrictive and intensive daytime activities. In FY92, MHC conducted a Day Treatment Program serving a total of 511 individuals (average daily census of 117), and ASD contracted with four agencies which served a total of 428 people.

Self-Help / Education / Advocacy

In FY92, ASD provided funds to one organization with over 400 members whose primary mission is to provide education, support and advocacy services for people with mental illness and their families, (although other organizations mentioned in the Risk Reduction and psychosocial rehabilitation clubhouse categories also provide these services in

addition to their other activities). Services provided by this organization include a monthly educational program, a monthly newsletter, family support group meetings, a reference library, public education activities to combat stigma, legislative and governmental advocacy, a housing assistance program, and a protective payee program assisting 33 people (see below).

Income Management

In addition to the protective payee program for 33 people mentioned above, ASD contracted with two community agencies in FY92 to specifically assist individuals with income management activities. One of these organizations provided representative payee, financial counseling, and money management services to 25 individuals. A second organization provided corporate guardianship services for 17 people found incompetent and in need of a guardian.

Outpatient Services

These services include individual or group counseling, and medications and medication monitoring (medication assessment, prescription, and review provided by a psychiatrist or a nurse). In FY92, MHC operated six outpatient clinics geographically distributed throughout the county, which served a total of 8,073 people. In addition, ASD provided funds to three private general hospitals (Sinai-Samaritan, St. Michael and Children's) for outpatient services received by 1,322 adults with mental illness who needed fee reimbursement assistance.

Alternative Counseling

ADS provided support to one community-based agency in FY92 which provided short-term counseling services, using non-traditional counseling approaches, to approximately 500 individuals with mental disorders, most of whom did not have a diagnosis of severe mental illness.

Pre-Crisis Services

Homeless Services

In FY92, two programs were funded specifically to provide services to individuals who were homeless and mentally ill. The Mental Health Complex operates a mobile community clinic, which is staffed by registered nurses and a psychiatrist, and provides a variety of services, including assessment, consultation referral to other service providers,

assistance in meeting basic needs, medication prescription and monitoring, long-term psychiatric follow-up, case management for people waiting to get into a community support program, and crisis intervention. In addition, ASD provided funds to a health care organization to provide medical and community living assistance for 468 individuals who were homeless and mentally ill.

Jail / Forensic Services

Non-Certified CSP: In FY92, this program assisted 228 people with mental illness who were also involved in criminal proceedings. It is designed to provide screening and evaluation services, treatment and probation negotiations with the court, medication monitoring, and helping to meet people's basic needs for food, shelter and income during and after their forensic involvement.

Jail Diversion Program: This program identifies people with mental illness who are coming interfacing with the criminal justice system, and attempts to divert them from full involvement through triage to appropriate mental health services.

Evaluation and Treatment Services, House of Corrections: ASD contract for assessment, medication assistance, and counseling services for people with mental illness who are in the Milwaukee County House of Corrections, which is a short-term (one year or less) detention facility. In FY92, this service assisted 240 individuals.

Forensic Outpatient Evaluation Program: This program, which is operated by MHC and located at the County jail, offers court consultation, outpatient evaluation of psychiatric status in individuals charged with criminal acts, evaluations for civil commitment proceedings and consultation concerning jurisprudence and public policy information. In FY92, the program served 695 people.

Jail Services: At any given time, there are as many as 80 to 100 inmates in the Milwaukee County Jail who receive mental health services. There is a Special Needs Unit for approximately 21 inmates with mental illnesses and a Step Down Unit for less severely ill people which houses about 19 inmates. In addition, there are another 40 to 50 people throughout the institution who are receiving mental health services. Most of the people have a prior history of mental illness and need medications and support. It is estimated that at least 15% of the total jail population has serious mental illness. There is a team of a part-time psychiatrist, nursing, and nine social work staff providing ongoing, active mental health services within the jail.

Substance Abuse Counseling

In FY92, MHC operated a program which provided outpatient services to 727 individuals who abused alcohol, as well as drug-free individuals who were addicted to drugs, but who, with counseling, were judged able to maintain themselves without drugs. This program, which focuses on maintaining abstinence, social readjustment, and vocational rehabilitation, was originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, it has developed into a program which mainly serves persons with a primary disorder of substance abuse, due to the lack of services within the County for these individuals. In FY92, this program served, on average, 19 people per working day.

Crisis Response / Stabilization Services

Psychiatric Crisis Service (PCS)

This MHC-based program is available twenty-four hours a day to anyone experiencing a psychiatric crisis. It consists of a 24 hour crisis hotline, psychiatric evaluation and triage services, and a walk-in outpatient clinic. It is the service used by police officers for emergency detentions in Milwaukee County. In FY92, 8,707 individual adults used the MHC Psychiatric Crisis Service; of these, 15% (1,304) were seen by this service twice, and 11% (933) were seen three or more times in the year. At the extreme, 58 individuals were seen 10 or more times in FY92, with a range as high as 59 times. In total , PCS had 13,456 "visits" in FY92.

Adult Inpatient Services

Public sector inpatient services for adults with mental illness in Milwaukee County are primarily provided by MHC, although some ASD resources are allocated to inpatient services for individuals with mental illness in nursing homes or the State Institutions.

Acute Inpatient Services

The Acute Adult units at MHC provide inpatient care to individuals over age 18 who need short-term hospitalization. The purpose of the acute units is to provide therapeutic treatment to help persons return to live in their own homes. In FY92, there were 4 general acute units at MHC, with a total bed capacity of 96. In addition, there were two 24-bed Geropsychiatry units with specialized staff to provide services to people over 60. Together, these units had 2,683 total admissions in FY92, and served a total of 2,234 unduplicated individuals, with an average length of stay of 21.22 days. This latter number is deceiving, however, in that although the LOS for the majority of patients on

the acute units for the first quarter of FY93 was between 20 and 23 days, on any given day, 50 or more had a LOS of greater than 45 days and some had a LOS of over a year.

Doyne Hospital - MHC Site Inpatient Services

Doyne Hospital (formerly Milwaukee County Medical Complex) operates two 24-bed general hospital-based acute adult psychiatric units geographically located at Milwaukee County Mental Health Complex, which served 739 unduplicated patients in FY92. Unlike the acute adult beds described above, these two units are administratively managed by Doyne Hospital. There were 960 total admissions, with an average length of stay of 18.5 days.

Dual Diagnosis Inpatient Services

In FY92, MHC operated 55 beds staffed to provide treatment focused on polydrug use by adults. Similar to the Substance Abuse Counseling services offered by MHC, these inpatient beds were originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, these beds are mainly used to serve persons with a primary disorder of substance abuse, due to the lack of services within the County for these individuals. These units served 617 individuals in FY92, with an average length of stay of 16.3 days.

Rehabilitation Inpatient Services

In FY92, MHC provided long-term, non-acute care to 406 adults with mental illness. These services were provided at two different locations, with a total bed capacity of 320. Rehabilitation Center-City Campus, with 128 beds, and Rehabilitation Center-Central, with 192 beds in FY92. Both are Medicaid certified facilities licensed to operate as skilled nursing homes, and both serve geriatric and non-geriatric people with mental illness. (During FY94, Rehabilitation Center-Central will be down-sized from 192 beds to 82 beds for people with mental illness. In addition, 140 people with a primary diagnosis of developmental disabilities who reside in Rehabilitation Center-South will be transferred to Rehabilitation Center-Central. The Central facility is now referred to as Rehabilitation Center-Main Campus, and will be certified as a 222 bed Title XIX Nursing Facility with a distinct part-MR). Rehabilitation Center-Central had 17 new admissions in FY92, with an average length of stay of 1,617 days. Rehabilitation Center-City Campus had 15 new admissions, with an average length of stay of 63.62 days (out of a possible 149).

Nursing Home Inpatient Services

In FY92, ASD contracted with an Institute for Mental Disease nursing home in the county to serve four residents with a mental illness.

Wisconsin State Institutes

This component reflects funding for several different situations related to ten individuals served by Wisconsin State Institutions in FY92. By Wisconsin State Law, the individual's county of residence is responsible for financial reimbursement for these services. First, funds were expended for forensic clients who were found not guilty by reason of insanity and had a mandatory release date, but were found in need of further treatment, and therefore, financial responsibility for treatment rests with the county. Second, resources were expended for patients transferred from Wisconsin Correctional Institute to Wisconsin Resource Center for treatment prior to their mandatory release date, and were then in the same situation as described above. Third, resources were expended for difficult patients who were transferred from MHC to a state institution for more secure, intensive treatment. Fourth, county resources were expended for state institution services provided to Milwaukee County residents who were detained there by another county until transfer to services within the county could be arranged.

REVENUE SOURCES

Funding for public sector mental health services comes primarily from the state, county, or third party reimbursements, such as federal programs (Medicaid, Medicare, Block Grants, and so forth), private insurance, and self pay. Table 2 reflects these different revenue sources. Community Aids (51.42 or CCSB Funds) is state / federal general purpose revenue, requiring county matching funds, allocated to counties for human service needs. Tax Levy is county based funds, allocated at the direction of the County Board of Supervisors and County Executive. Milwaukee County Health Care Financing Program funds are county / state dollars for people who are indigent or deemed medically indigent due to limited financial resources and need medical or psychiatric care. Institution for Mental Disease funds are allocated to counties by the state to pay for inpatient or community-based services for individuals with mental illness who have long-term needs. Federal and State Medicaid and Medicare revenues are reflected in the T-18 T-19 column. The Other category combines revenues that are not easily transferable to different service components for various reasons. Included in this category are revenues generated through self-pay, private insurance, contracts with other agencies, state CSP and COP revenues, other federal revenues (grants to provide specific services for specific populations), and so forth.

The revenue source information in Tables 1 and 2 is based on FY92 Actuals, as reported by the Adult Service Division and the Mental Health Complex. All revenues are for adult mental health services only. FY92 information was used because it was the most complete information available across all sources at the time of this report. Table 1 presents the total payments made by the Adult Services Division to contracted agencies (excluding dollars transferred to the Mental Health Complex) for adult mental health services, the other revenues received by these contracted agencies for their adult mental health services (in addition to those received from ASD), and the total revenues received by the Mental Health Complex (including those transferred from ASD) for their adult mental health services. The sum of the revenues for these three organizations represents the best possible approximation of the total funds spent on public-sector mental health services for adults in Milwaukee County in FY92 ($80,511,063). This represents a mental health funding ratio of $113 per adult capita.

As can be seen in Table 1, a majority (61%) of the total revenues for adult mental health were used to support inpatient services. When Community Based Residential Facilities are included, this percentage increases to 68% of the revenues allocated for facility-based residential services.

The majority of the revenues (82%) were reported by the Mental Health Complex ($65,857,963), while ASD revenues allocated to contract agencies represented 10% of the funds in the county mental health system, and the contract agencies generated another 8% of the funds.

Of the revenues provided to contract agencies from ASD, 40% funded community based residential facilities, 25% funded certified or non-certified Community Support Programs, 14% funded vocational or clubhouse services, 6% funded day treatment programs, 5% funded inpatient services, and the remaining 10% supported various outreach (9%) and risk reduction services (1%).

The revenues generated by the contract agencies themselves primarily supported community based residential facilities (34%), outpatient counseling services (31%), day treatment programs (17%), and community support programs (9%). The remaining 9% funded risk reduction services (3%), vocational or clubhouse services (2%), and other miscellaneous services (4%).

Within the Mental Health Complex, 74% of the revenues funded inpatient services, 10% funded outpatient clinics, 7% funded the Psychiatric Crisis Service, 4% funded the Medical Day Treatment program, and the remainder (5%) funded various community outreach services.

Table 2 presents information on the sources of the revenues collected by all three organizations (ASD, contract agencies, and MCMHC). Across all services, 27% of the revenues were from Community Aids funds, 25% from Medicaid / Medicare Title 18

and / or Title 19 funds, 12% from Milwaukee County Tax Levy, 11% from Milwaukee County Health Care Financing Program dollars, 9% from state Institute for Mental Disease funds, and the remaining 16% from other sources (mental health block grant and other federal sources, state CSP funds, COP, self-pay, and miscellaneous sources).

A majority of the Community Aids dollars (76%) supported services in the wellness and rehabilitation category, while a majority of the Health Care Financing Program funds (90%) and the miscellaneous revenues (52%) supported inpatient services.

Analysis of the use of County Tax Levy dollars is not as straight-forward. The total amount of tax levy funds available for public sector mental health services in FY92 was $9,818,545. However, the bracketed Tax Levy figures in Table 2 represent the mechanism used by MHC accounting allocation procedures to evidence service areas where revenue exceed expenses and to designate use of tax levy dollars elsewhere (i.e., the bracketed numbers for Geropsychiatry Triage Program, COP, day treatment, and outpatient clinics). In essence, almost all FY92 tax levy dollars were used by MHC to support inpatient services, and these tax levy funds provided the most of any revenue source for inpatient services (28.5%), closely followed by Medicaid / Medicare revenue (26.6%).

Within inpatient services, 61% of all inpatient revenues supported long-term rehabilitation units. County Tax Levy dollars provided the most revenues for rehabilitation services (41%), while state Institute for Mental Disease funds provided 30% of the revenue, and Medicaid / Medicare provided 23%.

Long-term rehabilitation inpatient programs accounted for 57% of all inpatient revenues provided by Community Aids, 68% of the revenues provided for inpatient services by Tax Levy dollars, 99% of the state Institute for Mental Disease funds (targeted to long-term care), none of the Milwaukee County Health Care Financing Program funds, 40% of the Medicaid / Medicare revenues for inpatient services, and 52% of the miscellaneous revenue sources supporting inpatient programs.

Acute inpatient services were primarily supported by Medicaid / Medicare revenues (44%) and Health Care Financing Program funds (32%). Only 10% of the revenues supporting acute inpatient services were provided by County Tax Levy and none were provided by Community Aids.

General acute inpatient services accounted for none of the inpatient revenues provided by Community Aids, 12% of the revenues provided for inpatient services by Tax Levy dollars, none of the state Institute for Mental Disease funds (targeted to long-term care), 69% of the Milwaukee County Health Care Financing Program funds, 55% of the Medicaid / Medicare revenues for inpatient services, and 34% of the miscellaneous revenue sources supporting inpatient programs. (See Appendix D for more detailed information on revenue sources reported by each organization.)

PRIVATE SECTOR SERVICE PROVIDERS

The public sector services listed above and reflected on Tables 1 and 2 represent both the adult mental health services provided by the Mental Health Complex and twenty-four private providers who receive contracts from the Department of Human Services to provide mental health services to adults in Milwaukee County. Mental health services also are provided by a wide variety of other private providers and facilities in Milwaukee County, including individuals in private practice (psychologists, psychiatrists, social workers, and counselors), private clinics, and psychiatric units in various hospitals. Fees for these services are typically paid by the individual or through insurance coverage.

As noted above, ASD provided partial reimbursement to three general hospital psychiatric clinics (Sinai-Samaritan, St. Michael's and Children's) for outpatient services provided to a total of 1,322 adults with mental illness in FY92. In effect, these are the only revenues which are directly associated with County public sector mental health services, in that these revenues are under the control of DHS.

There are several private general hospitals in Milwaukee County which also provide inpatient and outpatient psychiatric services to Medicaid-eligible patients. By definition, these are individuals who have a disability, and are receiving psychiatric care. As such, it is safe to assume that most are individuals who might otherwise seek services from the public sector mental health system.

Inpatient Services

Twenty-nine private general hospitals in Milwaukee County provided inpatient psychiatric services to 1,818 Medicaid-eligible persons (all ages) in FY92. By definition, these are individuals who have a disability, and are receiving psychiatric care. As such, it is safe to assume that most are individuals who might otherwise seek services from the public sector mental health system. Together, three of these hospitals (Sinai Samaritan, St Mary's Hill, and St. Michael's) served approximately 690 adults in their inpatient psychiatric programs in FY92 for whom Medicaid was billed $4,623,809 for their care.

In addition, thirty-six general hospitals also provided inpatient services for 3,682 persons (all ages) whose care was reimbursed by Medicare, also indicating that most are individuals who might otherwise seek services from the public sector mental health system. In FY92, Sinai Samaritan reported serving a total of 290 people (all ages) in their inpatient psychiatric program for whom Medicare was billed $2,692,416. Using a 15% adjustment factor for children and youth, the Medicare charges for adults served by this one hospital would be an estimated $2,288,500 in FY92.

Outpatient Services

Together, three of these general hospitals (Sinai Samaritan, St Mary's Hill, and St. Michael's) reported serving approximately 2,152 adults in their outpatient psychiatric clinics in FY92 for whom Medicaid was billed for their care. Charges billed to Medicaid, either through Medicaid-Wisconsin or Medicaid HMOs, for the outpatient services provided by these three general hospitals totalled $1,140,964 for FY92.

These same hospitals also provide outpatient services for persons whose care is reimbursed by Medicare. For example, in FY92, Sinai Samaritan reported serving a total of 876 people (all ages) in their outpatient psychiatric clinic for whom Medicare was billed $363.383. Using a 15% adjustment factor for children and youth, the Medicare charges for adults would be an estimated $308,876 in FY92. It also can be assumed that the other general hospitals also served people similar to those served by Sinai Samaritan.

DEPARTMENT ON AGING

The newly created Department on Aging also has a number of clients aged 60 and older who have mental health needs. Date from various sources was reviewed to identify the number of elders with mental health problems being served in Milwaukee County the following programs in FY92. Within the Milwaukee County Department on Aging, 108 persons in ongoing caseloads were identified by existing MCDA staff as having serious mental health problems. Two units of workers submitted no report. An unknown number of persons were identified as being in a "holding zone" (approximately 500 cases total). In addition, there are a number of unknown new referrals (the department just began a screening process in October, 1993 to identify elders with mental health / alcohol problems).

A total of 132 unduplicated persons receiving mental health services through the Adult Services Division will be age sixty years or older as of January 1, 1994. Services they receive include CSPs (57 people), Day Treatment (23 people), Protective Payment Services (13), Outpatient Clinics (19), Sheltered Employment (2), Adult Family Homes (5), CBRFs (36), and nursing homes (3). (Unduplicated persons may receive more than one service). The total revenues for these services, based on 1992 actual contract expenditure, wa $651,567. In addition, 36 persons age 60 years and older, as of January 1, 1994, receive services through long-term support funding, such as the Community Options Program. Projected annual revenues for these services are $219,747.

At the Mental Health Complex, 1,445 admissions (across all inpatient and outpatient services) in FY92 were age 65 or older, and another 857 were age 55-65. The Geropsychiatry Triage Program served 1,043 unduplicated persons in FY92, and 38 elders resided in City Campus Central long-term care units. The Mobile Community

Clinic also reported 123 persons over age 60 who have major mental illness and are homeless.

Appendix C, Milwaukee County Department on Aging: Specialized Services Plan for People with Mental Health Needs, discusses current services provided for these individuals, as well as proposed services which would interface with the public sector mental health system in Milwaukee County.

SUMMARY

The public sector mental health system for adults in Milwaukee County is bifurcated in terms of service development, management, and resource allocation, with two different administrative organizations having responsibility for county and non-county based services. Much of the service system is focused on office-based outpatient services, medical day treatment programs, a single crisis response service, and acute and long-term inpatient care. There also has been some limited development of more outreach services, such as Community Support Programs, short-term evaluation and triage capacities, a psychosocial rehabilitation clubhouse, and vocational assistance. There are a variety of revenue sources with which to provide services for people with mental illness. Thus, the County has the capacity to examine and then revise the system based on its current service strengths and identified needs.

CHAPTER THREE:

CRITICAL ISSUES FACING THE PUBLIC SECTOR MENTAL HEALTH SYSTEM FOR ADULTS IN MILWAUKEE COUNTY

INTRODUCTION

The County of Milwaukee is at a crossroads in determining the future direction for its public mental health system. Over the past several years, a number of assessments and reports were commissioned to examine various aspects of the County's public mental health services, including a 1989 analysis of the need for long-term care beds, a 1989 analysis of the Mental Health Complex (MHC) completed by outside consultants, an evaluation of the implementation of physician leadership on an acting basis at MHC, and a Department of Health and Human Services initiated study of outpatient mental health services (see Appendix B, Documents Reviewed). Although these studies indicated a general dissatisfaction with the existing public mental health service system in Milwaukee County, the complexity of the issues involving mental health service delivery made it very difficult to affect any meaningful systemic change. As such, when the Department of Health and Human Services (DHHS) reorganized in 1990 to become the Department of Human Services (DHS), it was decided that the County's mental health service system needed a separate analysis from the DHHS reorganization process.

In 1991, as part of the second phase of the DHS reorganization, efforts began to look at the County's public mental health service system for adults. The Mitchell Company was hired in 1991 to prepare a background report intended to be used by a project team of community representatives and County officials to evaluate, and recommend changes for, the organization and delivery of services. The Mitchell Company's report attempted to describe the statutory obligations of the county to provide mental health services; the organization of mental health services, including programs provided by the County or purchased from community organizations; the financing of mental health services; and issues for further study. The report also recommended that the then Department of Health and Human Services not proceed with the analysis of the mental health system by a project team as described above, but rather first develop a master plan for public sector mental health services for adults in Milwaukee County that would establish a philosophy of care; assess service need; describe how the County could allocate resources to meet these needs; and determine the most effective organization of services to implement the plan. This document is an effort to respond to the need acknowledged by the County Board of Supervisors and the Department of Human Services for such a Master Plan.

In order to develop a Master Plan for the public sector mental health system in Milwaukee County, information was gathered about the strengths and weaknesses of the adult service system as it currently exists. In addition to the very informative discussions and guidance from the Master Plan Advisory Committee during the ten months of the planning project, individual interviews were held with 33 key informants throughout the County, approximately 230 individuals participated in 13 focus groups focused on this issue, and recent documents and reports written about the service system were reviewed by the consultants (see Appendix B). This section presents a summary of the key issues which emerged as a result of these activities, organized according to four elements of a comprehensive system: Vision, Mission, and Guiding Principles; Services; and Administrative Structures and Other Supports.

VISION, MISSION AND SERVICE DELIVERY PRINCIPLES

Strengths:

- There is a strong sense of community pride.
- Providers are more open to vision of comprehensive system than in past
- The community recognizes the need for comprehensive planning and the need to fill existing service voids. People want the Master Plan to serve as a tool for system management and implementation.
- The formation of the Milwaukee Coalition on Mental Illness is a positive sign of cooperation and vision among service providers, consumers, families, and advocates.
- The state system is based on a value of serving people in need, rather than on ability to pay.

Areas Needing Improvement:

- There is no explicitly shared vision, service philosophy, or goals within the service system on which to base funding decisions, direct service development or measure service effectiveness and quality.
- As such, the service system is crisis-oriented and reactive, and focused on maintenance rather than on consumer growth.
- There is little sense of the systems' responsibility for consumer outcomes, but rather a focus on program "ownership" of clients.
- The system is perceived to be overwhelmed.

THE SERVICE SYSTEM

SERVICE INTEGRATION / COORDINATION

Strengths:

- There is improved communication and service planning coordination between MHC and community mental health providers in last few years, especially through specific mechanisms, such as the CCRC.

Areas Needing Improvement:

- Specific programs have been created to meet needs, but instead are isolated components that are not coordinated with each other and do not allow easy access or interface for consumers. This results in a lack of service integration and follow-up between outpatient and inpatient services, and between different community services.

- There is no single responsibility for a person's service needs, regardless of location of service. As such, individuals "fall through the cracks"; discharge plans are not followed or executed; at Psychiatric Crisis Service intake, information from community service providers about community service use, medications, or treatment plans is only available on weekdays during normal working hours; and so forth.

- Geographical distribution of services is uneven, in that the crisis services are located several miles out of town, as are the county-run day treatment and acute inpatient services. Relatively few public sector services exist in the central city.

INDIVIDUAL SERVICE COMPONENTS

Strengths:

- The most valued components of the service system (as noted by almost all informants) are those services that provide non-office based outreach assistance to individual consumers and attempt to engage or serve people in natural settings:

  CSPs: These services are seen as very effective and "user-friendly, in that they accept people's problems, such as poverty, oppression, and stigma, and the resultant feelings of low motivation, social isolation, and so forth. The service approach is based on addressing these issues as primary component of treatment plan. In addition, CSPs are state reimbursable services.

Geropsychiatric Triage Program: This program is valued highly by Department on Aging staff as a very effective and responsive service available to older adults with psychiatric needs.

Community Consultation Liaison Program: CCLP provides quick assessment and triage in community settings, which often results in the person not having to access more intrusive crisis services.

Discharge Planning Services: Existing discharge planning services, such as Housing Follow-Along, Community Options Program, and Community Care Review Committee (CCRC), are very helpful, in that they facilitate the individual's successful transition from inpatient to community living.

Housing: Development resources for low income housing are available in the community. In addition, a new program run by the Milwaukee Housing Authority provides an Intervention Team that helps tenants with mental illness or histories of drug use to live in public housing by providing assistance after business hours and on weekends.

Home Health Care: The ability to provide health care in a person's home is seen as a very effective method for addressing this need for people with mental illness.

Vocational Services: Employment support for people with mental illness is very effective when people have the opportunity to access this service.

Psychosocial Rehabilitation Clubhouse Program: This program is seen as very effective in responding to consumers' needs, in that it is based on a model of empowerment and focusing on individuals' strengths and contributions. It has become very popular since beginning in FY92.

Homeless Services: Both the Mobile Community Clinic for the Homeless and the homeless shelter system are very effective services. They assist people to access resources for both their mental health and medical needs, and work cooperatively with other components of the mental health system. The Coalition for the Homeless is an effective organization that connects providers who serve this population.

Criminal Involvement Services: The Task Force on Forensic Services was very effective in facilitating development of needed services. Some of the recent positive developments include a .5 FTE psychiatrist at the jail with admitting privileges at MHC; a forensic psychiatric unit at the jail for evaluations; 8 FTE psychiatric social workers, entirely funded by the Sheriff's Department, who provide classification, coordination, and crisis intervention services; a 19-bed special needs unit in the new jail opening within the next month; and cooperation between the District Attorney,

Corporation Counsel, jails, MHC, and other institutions to conduct case planning on a quarterly basis.

Inpatient Services: Small specialty inpatient programs, such as the Geropsychiatry Program, are very effective, in that clinicians and staff are well-trained to address the specific clinical needs of the patients.

Areas Needing Improvement:

- *CSP / Case Management*: Only the few clients who are served in the existing CSPs or group homes receive case management services that provide service coordination, assistance with daily living needs, and attention to crisis prevention activities. Existing CSPs have a waiting list of 1 to 3 years, and only about 3 to 7 people per year transition from CSPs. There also is no mechanism to follow-up with people after contact with PCS or to maintain continuity of care while receiving inpatient services and at discharge. Many people need these services to enable them to avoid initial or repeat hospitalizations. CSPs are the type of service reported as most needed by the 218 respondents in a 1991 survey of consumers in Milwaukee County, was the highest priority service as identified by provider agencies at the CY1993 Mental Health Block Grant Funds Community Input Meeting, and was identified as one of the top three needs by the consumer focus groups asked for input on Block Grant Fund use.

- *Housing*: Affordable housing is a major need, and is the most preferred housing situation for consumers within Milwaukee County. (A 1991 survey of 218 consumers in Milwaukee County found that 81% preferred living in their own apartment or home.) However, housing access and development has not been seen as a priority within ASD, the County or the City of Milwaukee; no one in ASD has the understanding necessary to network within the housing field; and existing housing services for people with mental illness are very disjointed.

- *Residential Programs*: Although emphasis has been placed on Community-based Residential Facilities (CBRFs) rather than supported housing development, this is not the type of housing that most people prefer; the housing preference survey conducted in 1991 found that only 8% of the respondent wanted to live in a group home. For those that do need or want the structure of a residential facility, CBRF regulations restrict use by people with substance abuse or violence problems, and the county has developed a policy that people residing in CBRFs are not eligible for CSP services. Another problem is that most group homes are only staffed 16 hours a day, and thus have requirements that residents be involved in a structured day activity. Many consumers are not willing to meet this requirement, especially those that may have had negative experiences with the formal service system (e.g., people who are homeless, people who have used multiple services over the years).

- *Vocational Services*: There is little coordination between CSP clients and existing vocational services, and no mechanisms to identify the people served by both systems, to identify CSP clients needing vocational services, or to ensure that CSP clients are served by existing vocational services.

- *MHC Day Treatment*: The location of this program makes it difficult to access, and public transportation takes a very long time to get to MHC. There is a perception that services also are not flexible enough, and too focused on people with intensive issues, to meet all consumers' needs.

- *Payee Services*: There is a large waiting list for protective payees, since there are too few CSP or case management services available given the need.

- *MHC Outpatient Services*: MHC Outpatient services had a no-show rate of 15% in FY92, possibly due to location, singularity of service offered (only outpatient therapy and medication monitoring), use of the individual therapy model, inflexibility re: appointment times, and waiting periods of 1 to 3 months for referrals. They are primarily used as post-discharge resources rather than as preventative services. They also have no focused client outreach or capacity for follow-up. In addition, the Central Walk-in Clinic AT MHC is not resource efficient, in that it serves as the referral clinic between other outpatient clinics and the PCS (if inpatient services are not needed), and it is difficult to provide the brief intensive clinical services it was also designed to provide.

- *Respite Services*: There are no resources for providing respite services to families that have a member with mental illness living with them.

- *Mobile Community Clinic*: This program cannot adequately handle the demand with existing resources, primarily due to inadequate staffing and inadequate availability of CSP services for referral.

- *Forensic Services*: Judges require that people stay in jail until mental health resources are available to serve them. As such, if community services are full, or if someone has "burned out" the system, they remain in jail regardless of severity of crime.

- *Substance Abuse Services*: The only services which exist specifically to serve individuals with both mental illness and substance abuse is the 55 bed inpatient program at City Campus and the MHC Breakaway Outpatient Clinic. However, due to lack of other substance abuse services, these programs actually do not serve persons with a primary diagnosis of mental illness, and instead serve people with primary substance abuse issues. In addition, there is a need for an AODA program that assists elders.

- *Geropsychiatric Services*: With the exception of the Geropsychiatry Program at MHC, there is a lack of awareness and skills in dealing with elders' specialized needs. There are staff of the Department on Aging (MCDA) who are mental health specialists, but the Department does not have the resources to allow them to focus specifically on this population or this issue. Other MCDA staff need training and technical assistance to identify mental health problems in people they serve. In addition, there are no resources for in-home services to elders. When MCDA was created, there was an agreement that all resources in the 51-42 system for people over 60 would be transferred to the Department on Aging, but this transfer has not yet occurred. Appendix C contains the Milwaukee County Department on Aging: Specialized Services Plan for People with Mental Health Needs.

- *Crisis Services*: The Psychiatric Crisis Service (PCS) at MHC is the only crisis service available in Milwaukee County. There are no other outreach crisis intervention services, alternative residential crisis services, or crisis prevention supports. Sometimes there is a wait of up to 4 hours to be seen at PCS, and consumers report that PCS response (timeliness and quality) varies by staff.

- *Inpatient Services*: There is no focused role for inpatient services within the overall system. As a result, MHC has traditionally functioned as the primary resource to address intensive needs. There is an open intake gate, resulting in a large number of adult acute admissions each year (2,683 in FY92). In addition, the average daily census for MHC adult psychiatric units (acute and rehabilitation) in FY92 was 567 (80 beds / 100,00 adult population), which is much higher than many of the "model" urban mental health systems in the country. Patients in both the acute and rehabilitation units also often have longer lengths of stay (LOS) than may be necessary, due in part to the unavailability of rehabilitation beds for people from acute units, inadequate resources for discharge planning from both acute and rehabilitation units, and system values focused on client maintenance rather than growth. Although the LOS for the majority of patients on the acute units for the first quarter of FY93 was between 20 and 23 days, on any given day, 50 or more had a LOS of greater than 45 days and some had a LOS of over a year. Many people in acute and long-term placements could be discharged, but several factors prevent this: inadequate community services; limited resources dedicated to coordination between inpatient and community services for individual patients; and inadequate resources for linkage with public benefits. This over-reliance on inpatient services not only affects client outcomes, but also results in low staff morale within the inpatient service system.

ADMINISTRATIVE STRUCTURES AND OTHER SUPPORTS

SYSTEM RESPONSIBILITY AND OVERSIGHT

Strengths:

- The Director of the Department of Human Services initiated this project to develop a Master Plan for Mental Health Services in Milwaukee County, with attention to the issue of system authority and accountability.

- The ASD contracting mechanism for services produces a healthy marketplace for service development and improvement.

Areas Needing Improvement:

- The County Governance structure, with the County Board of Supervisors and Health Committee as the ultimate authority, is cumbersome, inhibits timely decision-making and creativity.

- There is no single point of authority with the resources or focus to pro-actively address the needs of the mental health system. Wisconsin legislation mandates that there be a single point of accountability for service planning, funding, and monitoring; this also has been found to be a vital component of successful mental health systems around the country.

  In Milwaukee, the Department of Human Services has the ultimate authority for the mental health system. However, the Administrator of this Department has responsibility for all child welfare, juvenile corrections, adult disabilities and public welfare services, with the exception of Adult Corrections and Aging. Within the Department of Human Services, the Adult Services Division oversees the Mental Health Bureau (which has primary responsibility for all mental health services other than those delivered through the Mental Health Complex), Alcohol and Drug Abuse, Developmental Disabilities, Physical Disabilities, and Access and Brief Services. A separate division, the Mental Health Division, oversees all services provided by the Mental Health Complex. As such, there is no fixed entity with a single focus on mental health which also has the responsibility to oversee ALL mental health services (those offered by the county-operated Mental Health Complex and those offered through provider agencies which contract with ASD). The result is a fragmented system, without the ability to develop comprehensive plans or policy, integrate / coordinate services, monitor service quality, coordinate with the State Bureau of Mental Health on state initiatives / policies, attend to Health Reform issues in the County, or target and be accountable for fiscal resources.

- Lack of planning and ability to develop a unified, proactive budget results in unfocused service development. Obtaining and summarizing the information about these revenues was challenging for the project consultants and for the MHC and ASD staff who provided it to the consultants. There is little understanding between ASD and MHC about revenue sources and allocation, and the methodologies used for fiscal tracking differ significantly. As such, it is not possible, without a significant degree of staff time and effort, to develop a fiscal picture which reflects the total resources within the mental health system in Milwaukee County.

- Financial contingencies limit innovations. Since MHC is County-owned, there is concern by the County Board to develop new services that may need tax levy support. This situation results in limited funding for new or innovative programs or services, and a perpetuation of the reliance on inpatient services as the primary mode of care.

- There are few mechanisms for policy development and service integration between DHS and other related organizations, such as the Milwaukee Medical Complex, the Department on Aging, and the court system (circuit courts, children's court, and municipal courts).

- From the County's point of view, the State is seen as prescriptive re: service provision, and doesn't seem interested in local input or flexibility. It is unclear whether the State's role is to provide technical assistance or to supervise service development and delivery. From the State perspective, the County is seen as very defensive in discussions with State, is not seen as open to the State's ideas for service development, appears unwilling to share information about resource allocation, and so forth. The result is that the County has received little assistance from the State for service development, and the State considers the County to be resistant to change.

- Information about service directions and positive developments in the mental health system is not readily available to the provider system or to the media for proactive public education.

- The Matrix system of management at MHC has become a focus of concern for a number of reasons: there is little clarity about the respective roles and responsibilities of Program Administrators vs. Discipline Administrators; staff are confused about who to report to; daily staffing assignments are at the discretion of Discipline Administrators, which can result in inadequate program staffing and individual staff frustration; and program budgets are not controlled by program managers.

CLIENT INFORMATION

Strengths:

- MHC is interested in developing an MIS system that will provide patient demographic and clinical information across all MHC service programs.

Areas Needing Improvement:

- There is minimal ability to track service use of individual clients, to identify people who use / need intensive services, or to identify unduplicated count of people receiving services in a given timeframe. In addition, the data system does not provide adequate information about patients, including previous hospitalizations, medications, community service use, and so forth.

HUMAN RESOURCE DEVELOPMENT

Strengths:

- The public mental health workforce in Milwaukee County is very committed to helping people with mental illness.

- Inpatient and CSP staff are experienced in working with people with complex needs.

- There are excellent resources for professional training opportunities, including UWM, MATC, Medical College, UW Psychiatry. In addition, MHC provides a good training ground for students, residents, other staff.

- Recent changes in MHC management have brought a more effective and sensitive administration. The Administrator is seen as a good manager, with a strong understanding of systems issues and a "can-do" attitude.

- There is support within the workforce to implement innovative ideas.

Areas Needing Improvement:

- It is difficult to recruit and retain high quality staff (especially psychiatrists) with appropriate educational training due to low salary levels, inadequate benefits, hiring and salary freezes, and so forth.

- There is little ability to reward positive staff performance or correct performance insufficiencies.

- MHC has the highest vacancy and turn-over rate of any department in the county. Morale and creativity among staff is stifled due to the administrative structure, inadequate job descriptions and accountability mechanisms, and confusion re: MHC mission and role.

- All system staff need training opportunities, including a focus on the mission of the service system; values and principles of good service delivery; innovative service approaches; positive outcomes possible for people with mental illness; and specific skills training. In addition, opportunities to interact, develop linkages with other community organizations, universities, and private sector providers would strengthen staffs' sense of purpose, satisfaction, and pride in their work.

ETHNIC AND CULTURAL DIVERSITY

Strengths:

- There is recognition by DHS and MHC Administrators of the need to develop culturally relevant services, and to have staff who are similar to clients in terms of cultural and ethnic backgrounds.

Areas Needing Improvement:

- There is inadequate representation of minority providers, staff and services within the entire mental health system. This results in a lack of cultural sensitivity throughout the system.

CONSUMER INVOLVEMENT

Strengths:

- The Grand Avenue Club and Our Space Consumer Center are extremely valued service components by consumers, and are seen as positive additions to the service system by providers.

- The Consumer Advocates for Mental Health is a strong vehicle for consumer advocacy.

- The Milwaukee Coalition for Mental Illness is a positive example of consumers having a vital role in developing collaborative relationships with service providers to better the service system.

- The Milwaukee Chapter of the Alliance for the Mentally Ill is a strong advocacy vehicle for family members.

Areas Needing Improvement:

- Consumers and family members are not involved enough in policy development and planning in Milwaukee County. This was very evident in the activities conducted to develop this Master Plan, in that very few consumers were involved in the Advisory Committee meetings. High consumer involvement has been a key element in the development of the most successful service systems around the country, and is the most effective mechanism for keeping system development relevant to consumer needs.

- Consumers are not involved enough in service delivery.

- Consumers are not involved in service evaluation.

- There is limited capacity for organizing self-help and other consumer directed activities.

LEGAL ISSUES AND REPRESENTATION

Strengths:

- The State Chapter 51 legislation is considered a national model.

- From one perspective, the existing civil commitment procedure provides quality representation, in that the lawyers know the law and people's rights, and they try to negotiate settlement agreements to avoid unnecessary hospitalizations and to get appropriate community services.

- Courts are willing to look at options for individuals, and provide services on-site at MHC and at the Jail.

Areas Needing Improvement:

- The comprehensive state laws are difficult to implement adequately with limited funds; although the state promulgates the laws and expects them to be implemented, it is left up to the County to provide the funding to do so. As such, the legal system is overburdened, and results in attorneys being unprepared, rushed, and unable to focus on the specifics of each individual's case.

- Corporation Counsel lawyers, who are responsible for representing the professionals' opinions at civil commitment hearings re: probable cause for commitment, are assigned to mental health on a monthly rotation basis, and often handle up to 22 cases a day.

- Up to twenty people under police detention may be brought to the PCS on a given day, and about two-thirds of these may need a detention determination within 24 hours and a probable cause hearing within 72 hours. Due to these large numbers, it is very difficult for legal representation to get adequate input from family members, community staff, and psychiatrists on the person's situation and needs. It is also difficult for the psychiatrist to get similar input to make clinical recommendations.

- When individuals do not meet the commitment criteria of dangerousness, settlement agreements are often negotiated in civil commitment procedures which dictate that the individual receive community-based services. However, there is no mechanism for following up on the community treatment provisions to assure that individuals receive the needed services. As such, it is not known if people receive the services they need.

- An individual may be charged with a crime, if it does not appear that the person meets commitment criteria, in order to "get them off the streets" since there are very few community services available.

- Legal issues slow the treatment and discharge process, due to the above issues.

SUMMARY

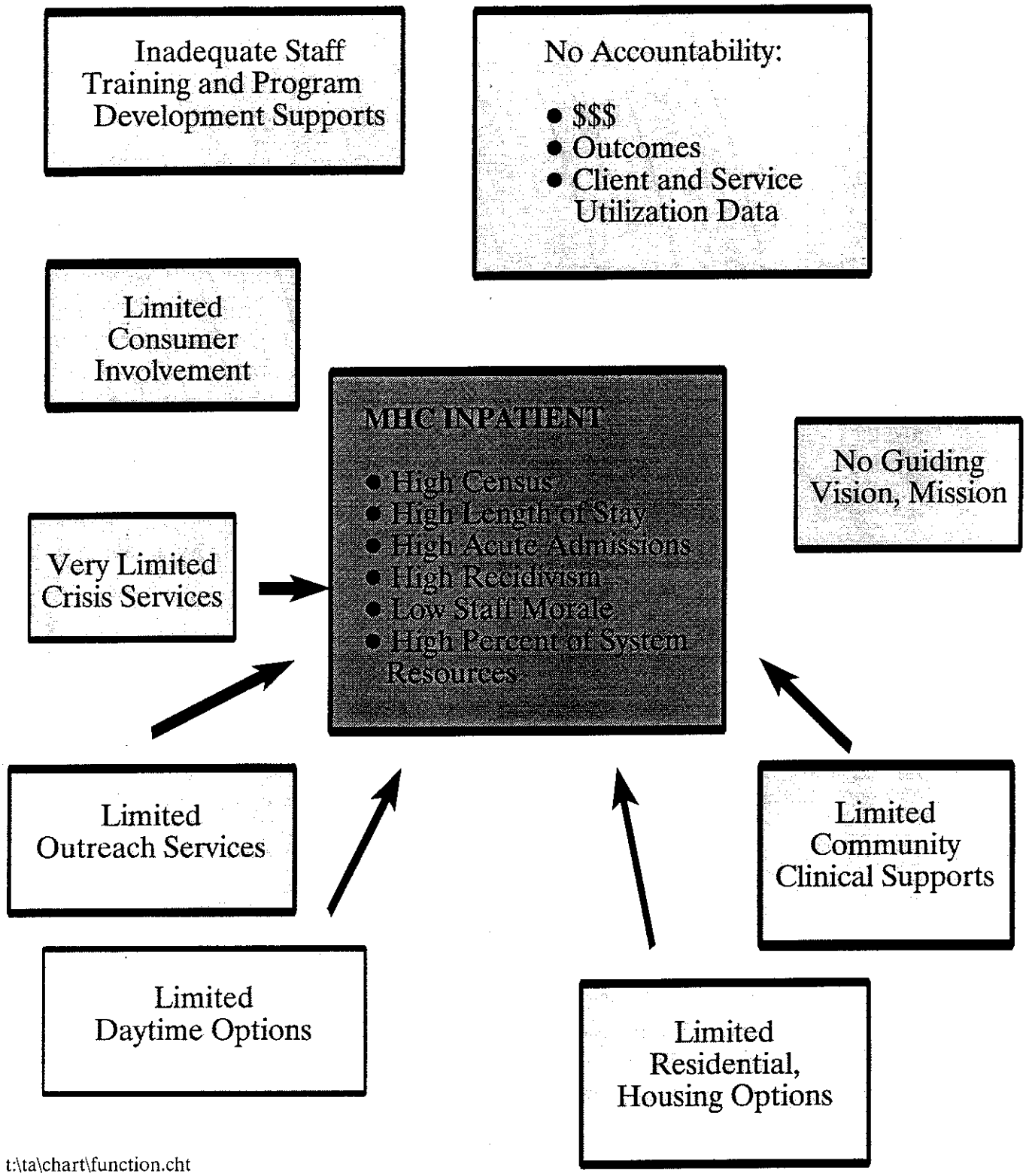
The public sector mental health system for adults in Milwaukee County has a number of strengths to provide the foundation for a comprehensive, well integrated service system focused on meeting individual consumers' needs. There is a collective understanding of the need to develop an integrated system of services that focus on consumer outcomes rather than on program maintenance. There also are a number of individual services in existence that have proved effective in helping people with mental illness to avoid the need for crisis intervention and inpatient care.

There are many issues within the system, however, that prohibit individuals from getting appropriate and effective services in a timely and cost-efficient manner. Services have developed in a non-integrated manner, with little attention to overall system needs. There is a bifurcated administrative structure which prohibits system-wide planning, fiscal oversight, information collection, or accountability. There also have been few resources directed towards enhancing the workforce to assist in the provision of relevant and effective services.

As a result, the system directs most of its resources to inpatient and office-based services, rather than outreach and wrap-around services which can prevent individuals from needing more intrusive, disruptive and expensive forms of care. A summary of this situation is graphically represented in Figure 6, and the effects on the individual consumer are represented in Figure 7.

Figure 6

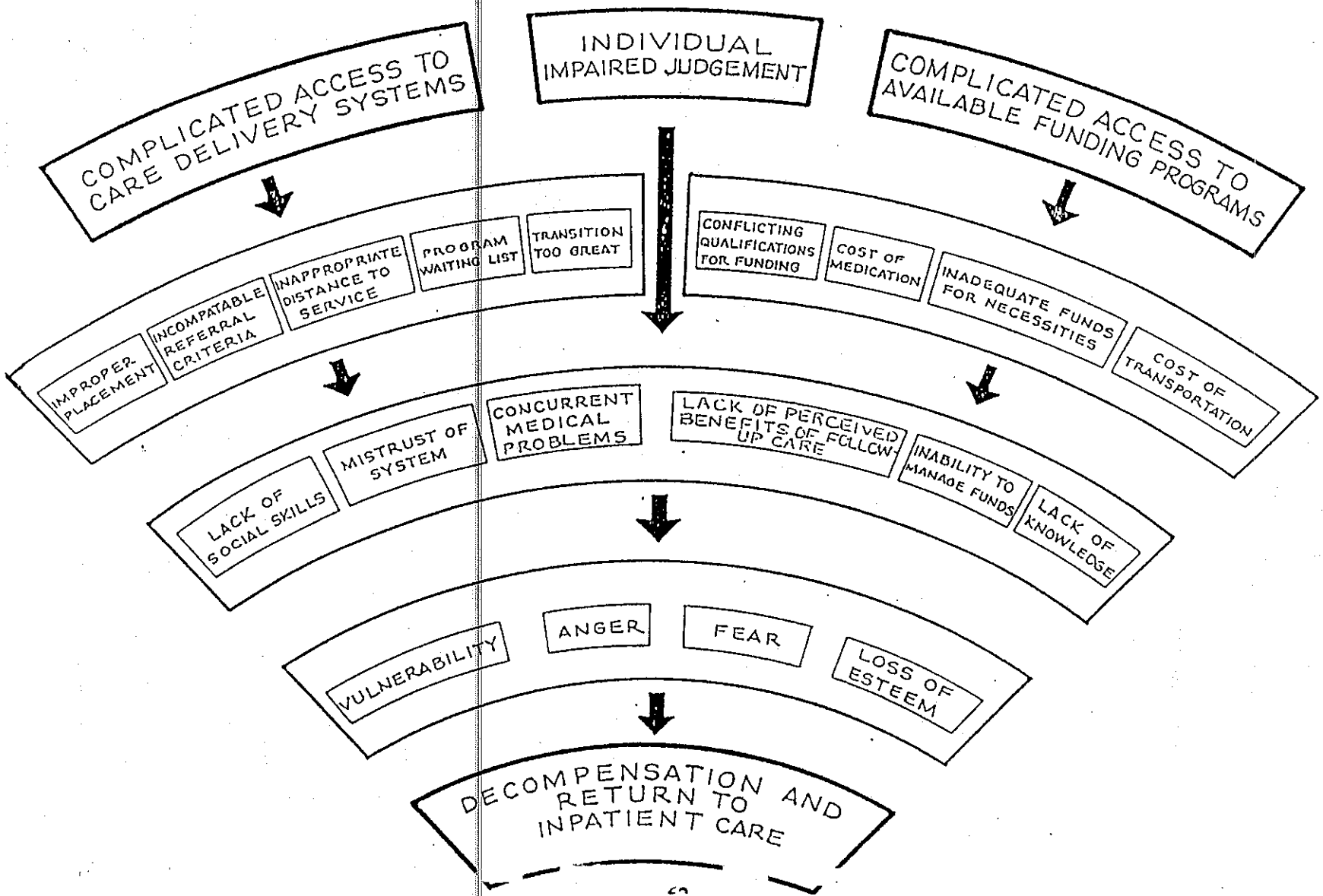
CURRENT FUNCTIONING OF THE PUBLIC MENTAL HEALTH SYSTEM IN MILWAUKEE COUNTY



t:\ta\chart\function.cht

Figure 7

EFFECTS OF CURRENT MENTAL HEALTH SYSTEM FOR PERSONS NEEDING SERVICE



SECTION TWO

THE PROPOSED SERVICE SYSTEM

CHAPTER FOUR:

A COMPREHENSIVE, INTEGRATED MENTAL HEALTH SYSTEM FOR MILWAUKEE COUNTY

INTRODUCTION

The County of Milwaukee recognizes that the current public sector mental health system for adults does not adequately meet the needs of it's citizens, as described in Chapter Three. As such, the County has initiated the development of a five year master plan to guide the development of a more effective and responsive system of services and supports for its adult citizens with mental illness.

The following assumptions form the foundation for the recommendations contained in this plan:

- The County of Milwaukee wants a comprehensive mental health service system, in which both inpatient and community-based services offer state-of-the-art, quality care for adults with serious mental illness. Therefore, the county wants a comprehensive plan that will chart a clear set of directions to achieve this goal.

- The County of Milwaukee wants a well-coordinated mental health system in which all components work together to achieve continuity of care for service recipients.

- The County of Milwaukee wants a mental health plan that facilitates an effective use of resources through improved accountability.

- The County of Milwaukee wants a fixed point of responsibility for service provision with clear roles, responsibilities, and authority.

- The County of Milwaukee wants its mental health service delivery system to be based on, and responsive to, the stated needs and preferences of its citizens with serious mental illness, and to be responsive to the needs of families.

- The County of Milwaukee is willing to develop a plan that is based on the needs and desires of people with mental illness, rather than on maintaining the status quo of existing provider agencies.

- The County of Milwaukee wants a mental health plan that builds on the planning already accomplished through previous efforts, and which addresses the practical challenges of implementing planning principles and goals.

- The County of Milwaukee believes that both quantitative and qualitative information is needed from a variety of sources to truly understand the strengths and weaknesses, and thus needed changes, in the current service delivery system.

- There may be no new resources to develop services. Therefore, the County of Milwaukee wants to develop a service plan that is realistic within existing financial constraints, but that also allows services to be revised to meet the needs of the county's citizens. The County also understands that new resources would enable greater strides towards achieving a responsive, comprehensive service system.

- The County of Milwaukee believes that service system changes cannot happen effectively unless all stakeholders are actively involved in the planning process.

BENEFITS OF THE MASTER PLAN

The request for proposals issued for development of this Master Plan stated that the consultants were to "develop a plan for a mental health system for adults in Milwaukee County which identifies the array of services and system coordination components Milwaukee County should support with its existing mental health service dollars. The Plan should also include what services or system coordination components are recommended to be supported if additional resources in $2 million increments were to be made available to the County." This Master Plan outlines a service delivery system that addresses most of the major issues existing within the Milwaukee County public sector adult mental health system without the need for on-going additional resources, except those in keeping with inflation. In fact, approximately $1,926,000 in tax levy dollars provided in FY92 within the Health Care Financing Program fund would be saved due to reduced reliance by the mental health system on Health Care Financing Program funds.

Due to the lack of an integrated management information system, it is difficult to know how many unduplicated individuals are receiving public sector mental health services in Milwaukee County. What IS known is that a majority of the adults served are primarily seen after they are in crisis, or through office-based clinic appointments that often are not very effective as the primary treatment modality for most persons with mental illness. As a result, the service system is in gridlock, with people cycling in and out of crisis and existing services, with no room for others in need to receive help. In contrast, the proposed service system is based on national urban prevalence estimates of the numbers of persons who should be expected to need public sector mental health services in the County at a given point in time, and the proposed service capacities are based on serving these people with the kinds of treatment approaches found to be very effective. By receiving these services, "persons with severe mental disorders will be able to participate more productively at home, at work, and in the community" (National Advisory Mental Health Council, 1993, p.1448). Not only does this benefit the people who progress, but it also makes services available for individuals who previously could not access needed services due to waiting lists and for those

who have newly developed needs for public mental health assistance. The benefits of comprehensive mental health systems also directly affect the family members of persons with mental illness, who are often the primary caregivers in under-developed systems and who live with the frustration and failure of the system every day.

In addition to the direct economic and humane benefits discussed above, estimates are available on the indirect costs associated with inappropriate treatment and inadequate services for persons with severe mental illness (National Advisory Mental Health Council, 1993). These indirect costs include lost productivity and lost earnings due to illness (morbidity), due to premature death (mortality), and the costs of related service and support systems, including social welfare, criminal justice, and incarceration. Based on national estimates, providing a comprehensive service system for Milwaukee's adult citizens with mental illness would result in a return of approximately $78,125 each year to the county economy in the form of earnings as a result of reduced mortality. In terms of increased productive capacity, it is estimated that the annual average wage loss per person with a severe mental illness is $6,442; as such, if only 10% of persons in Milwaukee County receiving appropriate services from Milwaukee County returned to part-time employment (.5 FTE) each year, it would result in an increase of $3,607,520 each year in the county economy due to wages. Reductions in social welfare, criminal justice system, and incarceration costs can also be estimated at a total of $195,300 in savings. The above total to a net savings in indirect costs of approximately $3,880,950 each year. In addition, it is estimated that comprehensive mental health services result in a 10% reduction in general health care costs; as such, tax levy and health care plan dollars supporting general health care costs for persons with mental illness could potentially be saved.

Comprehensive, effective mental health service systems also create indirect cost savings in terms of increased staff morale and productivity and decreased staff turnover, due to working within a system that assists people to improve and regain their personhood, rather than one that is can only respond to people in crisis and reinforces clienthood (Curtis, McCabe, Fleming, and Carling, 1993).

In sum, this plan outlines a service system that will provide direct and indirect humane and economic benefits to adults with mental illness, their family members, mental health workforce, and the taxpaying citizens of Milwaukee County by delivering high quality, proactive, and integrated services in settings that are most conducive for achieving positive outcomes.

The remainder of this Section presents recommendations to achieve these benefits according to three of the key areas discussed in Chapter One which are essential to the development and maintenance of an effective service delivery system: 1) the formation of a clear statement of vision, mission and service delivery principles that is shared by all major constituents in the relevant geographical area, and that guides service system development and implementation; 2) clear identification of services to be provided for specific target populations and the relationships between the individual service components; and 3) the development of administrative structures and supports to ensure that the service system functions in a way that achieves the vision, mission, and principles.

VISION, MISSION, AND GUIDING PRINCIPLES

One of the most important elements of a well-integrated, effective service system is a shared understanding, and explicit statement of, the outcomes desired for consumers of the mental health system (Vision), the role of the mental health system to help consumers achieve these outcomes (Mission), and shared values about what qualities make services effective (Principles). These Vision, Mission, and Principles are the guiding force of the service delivery system, and provide all constituents with a clear understanding of what everyone is trying to achieve. As such, they are the foundation of all service development and delivery, and should be used to hold the system accountable in every way.

During the course of the planning project, the Master Plan Advisory Committee developed and adopted the following vision, mission and service delivery principles to guide the Milwaukee County public sector adult mental health system policies, organization, resource distribution, program development, service delivery, program outcomes, and evaluation.

VISION AND MISSION OF THE MENTAL HEALTH SYSTEM SERVING THE PEOPLE OF MILWAUKEE COUNTY

The **VISION** of the mental health system serving the people of Milwaukee County is that the citizenry function at optimal levels of physical and mental health, and that individuals who have mental illness are full and equal members of the community. As such, the system shall provide individuals who have mental illness the support and the means to pursue success in the ways they choose to live, learn, love, work and play.

It is the **MISSION** of the mental health system serving the people of Milwaukee County to develop, coordinate, and provide multiple resources to help achieve this Vision. The resources are to include: a full range of quality risk reduction, diagnostic, treatment, and rehabilitation options; safe and affordable housing; learning, work, social and recreational opportunities; family and peer support; and self-help services. Implementation of this Mission will include the promotion of positive images of people with mental illness through the use of appropriate, non-stigmatizing language; and opportunities for positive contributions by consumers and family members in all aspects of service system governance, planning and delivery, including employment in the service delivery system.

The **GOAL** is to develop, direct and manage a readily-accessible and respectful system of community and inpatient support services that assist persons who have a mental illness to:

1) acknowledge, learn about, cope with, and recover from their illness;

2) gain skills and access to support systems to live independently;

3) have access to the best mental health services possible;

4) take responsibility for directing their own lives as members of the community; and

5) have opportunities for making positive contributions to the mental health service system and to their community.

The Department of Human Services, as the central mental health authority, in working with all consumers, families, providers, governmental agencies and advocates, will be held **ACCOUNTABLE** for providing:

1) strong system leadership, which helps the community at large to recognize its role and contributions in accomplishing this vision and mission statement and that people with mental illness are an integral part of the community; which strives to be on the forefront of service delivery; and which contributes to national research;

2) clear policy development;

3) assertive development and effective allocation of resources;

4) unified fiscal operations;

5) coordination of program planning and operations;

6) methods for monitoring and evaluating services that ensure the quality, coordination and effectiveness of care; and

7) positive consumer outcomes.

SERVICE VALUES AND PRINCIPLES OF THE MENTAL HEALTH SYSTEM SERVING THE PEOPLE OF MILWAUKEE COUNTY

In working to achieve the vision and mission of the mental health system serving the people of Milwaukee County, the Department of Human Services and its partners will be guided by the following values and principles:

- Adults with mental illness shall be given the **opportunity to lead productive lives** and make significant contributions to the communities in which they live.

- Persons with mental illness have the **right to be actively involved in and make choices about all aspects of their treatment**; this process shall be one characterized by **respect and dignity.**

- Treatment and support services shall be provided in such a way as to **minimize disruptions** in community living.

- The effective delivery of mental health services requires a **comprehensive, coordinated array of service options with 24 hour access and treatment.**

- The development and provision of services shall be **driven by the needs and desires of consumers.**

- **Family members have a unique, integral role**, and their needs and perspectives shall be included in the development and implementation of services.

- Taking **control over and responsibility for one's own life** is an essential factor in coping with and recovering from mental illness.

- A person's **natural support system**, including family, significant others, peers, self-help groups, and other community members and organizations are essential to recovery.

- An effective, responsive mental health service system provides consumers with a **meaningful choice** among services they use. Meaningful choice means that individuals are given viable alternative options for meeting their clinical, housing, employment, and social needs, including support and advocacy to support their choices.

- Decisions about where, with whom, and how to live, work, and socialize are inherently personal and differ for each individual. People with mental illness have the **right to select** their residences, work options, and social relationships **from the same range of options available to the general public.**

- People have the **right to select services and supports independent of treatment contingencies.**

- Mechanisms must be available to **ensure individuals' rights.**

- Services shall be highly **individualized and flexible**, recognizing the unique needs, desires, hopes and strengths of each person.

- An individual's **cultural origin, ethnicity, age, gender, sexual orientation, religion, changing needs, diagnostic category, severity of symptoms, and past history should not be used to deny access** to services.

- All **services should be relevant and responsive to the culture, ethnicity, age, and gender** of the persons served, and **staff should be given adequate training,** and demonstrate competence, in providing such relevant services.

- Effective service systems value the **empowerment, involvement and viable partnerships of staff,** and provide supports to ensure that they have adequate training and resources to perform their jobs competently, and with compassion, understanding and respect.

- The development of effective service systems requires **strong leadership and collaborative partnerships** among all key constituencies with clearly defined expectations, responsibilities, authority and accountability.

In order to have a service delivery system that is consistent with these Vision, Mission, and Principles, the County of Milwaukee must undergo a major system change initiative. Existing services must be refined or enhanced, new services must be developed, administrative structures must be re-organized, staff must be well trained and supported, an integrated information system must be available, and the focus of all aspects of the mental health system must shift to achieving positive outcomes for service recipients rather than maintaining status quo. By undertaking these changes, the County of Milwaukee will drastically alter the lives of individuals with mental illness, and will create a system that is fueled by hope rather than despair.

MILWAUKEE CASE STUDY VIGNETTES

JULIA

Julia is a 30-year old Hispanic woman. Before becoming involved in the mental health system, Julia had successfully completed high school, and was attending a local college, pursuing a nursing degree. She had held a variety of retail positions, including one in a pharmacy. Julia has had many challenges in her life, including her parents divorce, a history of being assaulted, and mental illness and alcoholism in her family.

Julia began receiving mental health services at age 23, when she had a nervous breakdown. At the time, she was delusional, and believed that people were trying to kill her. She experienced frequent "manicky" states, and at times her thoughts would race and she would become very confused. She also used marijuana and cocaine because they helped control her moods. She was committed by her sister and hospitalized at the Mental Health Complex for two months. She reports that her first hospitalization helped her, and "she felt better upon discharge, but was not well. She had a relapse within a month because she did not have any support, or take her medications, after discharge.

Both her second and third hospitalizations were one month emergency detentions by police at MHC, due to threatening and aggressive behavior towards other people. Julia reports that she did not want to act this way, but it was uncontrollable. Her third hospitalization especially frightened her because she was placed in a seclusion room, given injectable medications, and could see construction out the window and thought they were digging her grave.

Julia's fourth hospitalization, which was a two week stay at a local general hospital,helped her most. She received medication, counseling, group therapy, and participated in activities. Her medications were adjusted, and most, importantly, she was "treated as a whole person." She was given follow-up guidance and support after discharge, including regular participation in group programs and activities, and connection with a self-help drug abuse group, which she reports has helped her overcome her addiction, feel good about herself, and helped her with relationships. She feels that if any of her first three hospitalizations and post-hospitalizations were managed like her fourth, she would have approved sooner and avoided re-admission, and that being seen and treated as a whole person is the key, and that community supports are very important to maintaining positive mental health.

Julia is now living with her two children in an apartment. She has overcome her addiction problems, takes her medications regularly, copes well with her minimized symptoms of mental illness, eats well, and exercises regularly. However, she wants to stay busy and to have a purpose, and would very much like the opportunity to resume her associate nursing degree program. In order to do this, however, she would need assistance with returning to an educational environment, a much stronger support network, and help with her children so she could eventually return to work.

Although Julia is doing well right now, the proposed service system would provide Julia with the inpatient and follow-up services that would have prevented her from needing re-hospitalizations. In addition, it would provide her with the supports to help her develop stronger social networks, through psychosocial rehabilitation program, and help her obtain her degree and eventually return to the workforce, through assistance from a supported employment program. Hopefully, Julia also would be willing to use her experiences and knowledge to assist the mental health system to make needed changes in service delivery by participating on a governing or advisory board.

HAROLD

Harold is a 71-year old white male who was a successful small businessman for many years. Although Harold suffered from depression for about 17 years, he did not become involved with the public mental health system until the last four years. At that point, his wife contacted the Geropsychiatric Triage Team, which initially talked to her by telephone, then conducted a home visit, at which time they told her to bring him to be admitted as an MHC inpatient. During the past four years, Harold has been admitted three times to MHC, each for several weeks; during the third inpatient admission, he was given electroshock therapy. He finally was admitted to a nursing home, where he lives today. Once at the nursing home, it also was discovered that Harold had been suffering from a prostate problem, which was not diagnosed during his previous mental health hospitalizations. Harold's wife is now relieved that he is living in the nursing home, since his depression, and his need for care, continued to increase over time. However, she regrets not having access to community-based and in-home services and supports rather than having to use inpatient services, so that perhaps his depression could have been addressed more proactively, with less disruption, and perhaps a better outcome.

In the proposed service system, Harold and his wife would have been triaged to case management staff with a high level of specialized expertise in mental health problems among elders. They would come to Harold's home, assess both his medical and psychiatric needs, and offer a variety of support and clinical services. In the event he needed to receive intensive services outside his home, he would be offered a variety of crisis options and only hospitalization as a last resort. If he was hospitalized, he would receive intensive follow up support services. While at home, Harold and/or his wife would have access to support groups for persons dealing with depression, and would be offered information on coping with depression. Respite services would be available, in which a support worker would come into their home to spend time with Harold, and perhaps to get him out into a community activity, or even into a volunteer job where he could feel more useful and productive in his life.

GEORGINA

Georgina is a 42-year old African American woman. She has one grown daughter, an active social life which revolves around church and family, and manages her own household, where she lives with a teenage nephew. During the days, she attends a partial hospitalization program at a local general hospital. She also participates in group therapy, individual counseling, and receives medications.

Georgina has had many challenges to overcome in her past, including alcohol problems among most of her closest family, a head injury during childhood, and her parent's divorce. She has also had a history of high blood pressure. Although she had learning problems that prevented her from finishing high school, she held a variety of jobs, and particularly enjoyed working at the local YMCA.

Georgina's mental health problems began in 1978 when her father died. She was working at YMCA in Milwaukee at the time, and was informed by a phone call. She attended the funeral services, and subsequently began having fainting spells. She describes her "mind going bad." She began to do strange things that she did not understand. She bought things she did not need, sold her furniture without reason, and traveled to another state for no purpose. She felt this was a mental breakdown. She eventually saw a physician and was given medication. At that point she also had a short inpatient stay at MCMHC, but does not remember the details. She got better and returned to her job. She had no follow-up medications or treatment, and worked steadily until 1989.

She had a recurrence of her problems in 1989 and has received mental health services in Milwaukee continuously to the present, including four inpatient hospitalizations. Her main problem in 1989-90 was "hearing voices" that repeatedly told her to do bad things. She didn't know what she was doing, didn't know why she did things, and didn't care." She broke up with her boyfriend of a number of years, and now regrets it. At some period during 1991-92, she became very disturbed and was hospitalized, but does not remember very much about the episode. She often felt that she didn't want to get out of bed in the morning.

Her main problem now is feeling somewhat depressed and not happy. She was happy with her boyfriend and misses that relationship. She does not like being home alone, and feels that she needs to have places to go and things to do. She is somewhat satisfied with the day treatment program she attends Monday through Friday, but when she leaves in the mid-afternoon, she has a void, and feels similarly on the weekends. She would like to work and be with people, in that she feels more secure when people are around her. She tries to avoid being alone.

She would like to increase her social network and feeling of productivity, perhaps beginning by doing volunteer work, but does not know how to go about it. The opportunity to participate in a volunteer program would be helpful to her so that she could be with people and provide help to others. She would also like to have a chance to get into a job training

program. She believes that a return to work will provide what she wants the most: live a home life, pay bills, shop, and be a family person.

Georgina believes that if she had more treatment and follow-up in 1978 so that she understood her mental illness better that she may have avoided further breakdowns. She also feels that if she could have had opportunities to keep busy after her hospitalizations in 1989-1992, she could have avoided recurrence. She feels that support groups, support of family and friends, and some type of work would have helped her.

In the proposed service system, Georgina would have CSP staff available to help avoid future hospitalizations. The CSP staff would assist her to have opportunities to participate in meaningful activities during the day, including volunteer work, going to a drop-in center, involvement in a psychosocial rehabilitation program which focuses on developing social and vocational skills, connecting with self help groups, and working with a vocational specialist to achieve her employment goals. The CSP would also help her with her medication issues, and to have a better understanding of her illness and coping strategies that might be useful to deal with the symptoms. Over time, we would expect to see Georgina return to work, perhaps after a period of training, perhaps become involved in a significant romantic relationship, and be much more satisfied with her life and her prospects.

CHARLES

Charles is a 28-year old single white male who is an inpatient at MHC. Charles graduated from high school, and attended a local technical college, studying horticulture. He has had a variety of jobs, and enjoyed his landscaping jobs the most. Charles had a number of physical illnesses during his childhood, which frequently disrupted his early education; as a result, he had few friends, very low self-esteem, and was often in special classes. In addition, Charles' father had a history of mental illness, alcoholism, and suicidal tendencies.

Charles first heard voices very minimally when in high school at age 17. They became more frequent during his senior year, but he was able to cope with them and did not complain or seek help. He began receiving mental health services when hospitalized at Columbia Hospital in October, 1983. He was attending school at the Milwaukee Area Technical College, and found the studies highly structured and stressful. He became uptight, had trouble sleeping, and his head confused. He was troubled by hearing voices that were critical of him and threatening. He felt that secret discussions were being held about him, and that he was being monitored by cameras. The voices became so intense he sought help.

He has been using mental health services continuously since 1983, including eleven inpatient psychiatric hospitalizations. His main problems have been the persistent hearing of voices, low self-esteem, anger and depression, and a number of suicidal attempts.

He has been an inpatient continuously since 1988. He states that his mood is good, believes he can work, and would like to do things by himself. He does not like isolation and restrictions, and does not believe he should be on SOS (suicide observation status). He has received Electric Shock Therapy and does not believe that helped him.

He believes he is ready for discharge now and would like to do things independently. He wants to prove to himself and others that he can do it. Things are presently going too slow for him in the hospital. He sees others being discharged quicker than he is. He enjoys going home and having the support of his mother and brother, as well as being with his friends, going to sports events, and going fishing. He misses having the opportunity to do these things over the past five years.

Charles feels that if he had received help earlier, he would not be in the condition he is today. He also feels discouraged about his long term hospitalization, believing that each day the possibility of getting back to a successful life in the community becomes more distant. If he does get out, he believes it will be through a rigid succession of group homes, transitional employment opportunities, and other options that are simply too slow for him. He wants help re-learning, or learning for the first time, the skills he will need to get back to work, to have his own place to live, and to manage his symptoms.

In the proposed mental health system, Charles would have available, on a 24 hour basis, a variety of crisis services that would help him to stay out of the hospital, creating a basis for a more stable community life. He would intensive supports from CSP staff, who, in the period immediately after discharge, might visit several times a day, helping him take his medications and develop coping strategies to deal with the voices, and working out plans for how to spend time, budgeting, shopping, coping with loneliness, re-connecting with family, and building new relationships. If he had trouble coping, crisis specialists might even move staff into his home on a 24 hour basis to prevent hospitalization, or offer him a short stay in a crisis apartment. After some time, less support may be needed. Over time, we would expect to see Charles involved in psychosocial rehabilitation programs or work activity services, living in his own place, occasionally using non-hospital crisis services, and participating in a social network with his age peers.

CRAIG

Craig is a 31-year old white male, although he views his mental illness as his ethnic group. He lives in a subsidized apartment with several friends, who are also recovering psychiatric patients. He is a full time student at a local university, where he is studying social work. He is not involved in any mental health program, but sees a local psychiatrist periodically to review medication.

Craig was first committed at age 17, with an original diagnosis of schizophrenia, which was later changed to manic depression. He has been involuntarily hospitalized three other times since then, for periods of up to six months. In general, he did not find the services he received very helpful, in that they provided very little in the way of safety or treatment; however, they did provide him with a string motivation for him to find an alternative path to recovery. Craig views the networking and sharing with friends who also have a mental illness for problem-solving as the most important element of his recovery. He believes maintaining connections with individuals' natural supports, friends, and relatives are also vital to recovery. As an advocate for change, Craig believes that family members and people recovering from mental illness should be encouraged to visit and support people when they are in the hospital. Also, he believes that services should focus more on natural supports, and on learning to live with a mental illness over time, and on networking, sharing and problem solving with friends, rather than just on responding to crises. Finally, he wants to shift the focus of the system away from formal services, such as inpatient settings and group homes, toward subsidizing people to live in their own places, and enhancing or supporting the natural relationships in people's lives.

In the proposed service system, Craig would have access to case management, psychosocial rehabilitation staff and crisis services, so that he could use professional services when and where needed. He also would have the opportunity to be participate in efforts to increase the involvement of people with the mental illness in meaningful roles within the health system in the mental health system, and could possibly receive financial support to conduct advocacy work or the formation of self-help groups. Staff and policy makers also could request that Craig speak at public meetings, and be involved in other aspects of public education to improve understanding and acceptance of people with mental illnesses.

THE SERVICES

In order to achieve this Vision and Mission and the outcomes for people like Julia and Charles, major changes need to occur within the mental health system in Milwaukee County. Services have been developed without a functional mechanism for unified administrative oversight and without a clear focus on the desired outcomes for consumers. This has resulted in a system that is reactive rather than proactive; focused on maintaining services and programs rather than on assisting people in their own environments; and, using resources in a manner that is cost inefficient rather than cost efficient in terms of service quality and outcomes for consumers.

The remainder of this Chapter presents recommendations to change the service system, and to create administrative structures and other mechanisms that will support the implementation and on-going maintenance of a comprehensive, integrated public sector mental health service system for adults in Milwaukee County.

NUMBERS IN NEED OF PUBLIC SECTOR SERVICES

To plan effective service systems, it is necessary to develop an estimate of the numbers of people in the population who will need services in a given period of time. This enables resources to be allocated in appropriate proportions to meet this need, and also can be used as an indicator of whether the system is meeting the needs of the population it is intended to serve. Methodologies to make precise estimates of the numbers of people with mental disorders in a given geographical location are not available; however, recent advances in diagnostic criteria and epidemiological survey methodology have made it possible to develop more precise national prevalence rates which can then be used to estimate prevalence in local areas (National Advisory Mental Health Council, 1993).

The most accurate source of prevalence rates of mental disorders in the United States is the Epidemiologic Catchment Area (ECA) study, sponsored by the National Institute of Mental health in 1980-85. This study surveyed 18,571 households and 2290 institutional residents aged 18 and over in five areas of the country: New Haven, Connecticut; Baltimore, Maryland; Durham, North Carolina; St Louis, Missouri; and, Los Angeles, California. Information was collected, using standardized diagnostic assessment tools and a written survey instrument, through face-to-face interviews at a year one interval and telephone interviews in between. As such, data could be collected about changes in mental health status and service use over time.

According to the ECA findings, 22% of the adult population in the United States experiences a mental disorder within any given year. Of this 22%, 2.8% experience one or more severe mental disorders (schizophrenia, manic-depression, major depression, panic disorder, and obsessive-compulsive disorder). Although each of these mental disorders differ in cause, course and treatment for the individuals affected, most are long-lasting and can produce significant levels of impairment and interfere with daily functioning.

The ECA found that, of the 2.8% who experience one or more severe mental disorder, 62.4% will use mental health services, and 10% of these will use private sector services only. Of the remaining 19.2% who experience non-severe mental disorders, 38% will access mental health services during a year, and 73% of these will use private sector services only (Narrow, Regier, Rae, Manderscheid, & Locke, 1993). Many of these less severe mental disorders are relatively brief in duration, persisting at full diagnostic levels for less than a year.

Implications for the ECA point prevalence data for Milwaukee County are shown in the top half of Figure 8. Using ECA rates, the estimated number of adults with severe mental illnesses in Milwaukee County who need public sector mental health services at any time in a given year is 11,208 (1.6% of the County's adult population), while the number of adults with non-severe mental disorders who would want to access public sector mental health services during a given year is 14,048 (2% of the County's adult population). The 1.6% figure to estimate the number of the adult population with serious mental illness is also the formula recommended by the National Institute of Mental Health to develop state and regional plans for service provision (Manderscheid, 1992).

TARGET POPULATIONS

Increasingly, mental health service systems are targeting public resources to persons most in need (i.e., people with severe mental illness). In addition, they are defining specific subpopulations who have specific service needs, based on diagnosis, severity of functional impairment, and duration of functional impairment. Definition of these subpopulations allows more accurate estimation of the need for specific services. It also helps the system ensure that those who receive intensive resources are the people who are most in need.

Although criteria for establishing target groups vary, a workgroup convened by the National Institute of Mental Health has developed definitions for dividing persons with mental illness into target groups which indicate different service needs. Termed Clinically Related Groups (CRGs), these definitions have been adopted and utilized by systems throughout the country for service planning, contracting, implementation and evaluation.

Figure 8

METHODOLOGY TO ESTIMATE ADULTS IN NEED OF PUBLIC-SECTOR MENTAL HEALTH SERVICES IN MILWAUKEE COUNTY BY TARGET POPULATION GROUP

TOTAL MILWAUKEE COUNTY ADULT POPULATION 712,741

ESTIMATED PREVALENCE BASED ON ECA DATA:

	ECA PREVALENCE	MILWAUKEE COUNTY ADULT POPULATIO	ADJUSTMENTS	MILWAUKEE COUNTY POPULATION NEEDING PUBLIC MH SERVICES	
% with active severe mental disorders (one or more diagnosis) in a year	2.8%	19,957	62.4% will use any mh service	12,453	
			10% use only private sector svcs	11,208	Total SMI
				1.6%	% of Total Pop
% with non-severe mental disorders in a year	19.2%	136,846	38% will use any mh service	52,030	TARGET
			73% use private sector services	14,048	GROUP 4
				2%	% of Total Pop

PREVALENCE ESTIMATES OF TARGET GROUPS WITHIN SMI POPULATION:
(Using Tennessee CRG Results, Urban Population)

	Tennessee CMHA clients	Adjusted for 100% of Population		
Group 1	39.1%	42.4%	4,753	TARGET GROUP 1
Group 2	12.0%	13.0%	1,459	GROUP 2
Group 3	41.1%	44.6%	4,996	GROUP 3
Total	92.2%	100.0%	11,208	Total SMI

Following are the four definitions of the target population groups:

GROUP 1: Persons with Severe and Persistent Mental Illness

Persons in this group are recently severely impaired and the duration of their severe impairment totals six months or longer.

GROUP 2: Persons with Severe Mental Illness

Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

GROUP 3: Persons who were Severely Impaired

Persons in this group are not recently severely impaired but have been severely impaired in the past and need some on-going services to prevent relapse.

GROUP 4: Persons with Mild or Moderate Mental Disorders

Persons in this group either 1) have disorders that are not as severe in terms of diagnosis, duration or disability as those in Populations 1,2, and 3, or 2) formerly had a mental illness resulting in severe impairment but no longer need intensive services to prevent relapse. Persons in this group are typically individuals who are experiencing short-term situational distress that is disrupting their day-to-day functioning due to the emotional stress (e.g., experiencing divorce, job loss, loss of a loved one) or those whose lives are extremely stressed by the combined effects of poverty, violence and drug abuse, and that present at mental health services with exacerbations of mental disorders due to these stresses or acute emotional reactions to interpersonal conflict or disruption. As such, even though these individuals do not have a severe mental illness, they do need services to avert more severe problems in the future.

Over the past several years, the Tennessee and New Hampshire mental health systems have conducted studies to determine numbers of people using community mental health services within each of the first three target groups. The second half of Figure 8 indicates the percentages found in the Tennessee study, and the resulting estimates for Milwaukee County. The fourth target group is comprised of the people with non-severe mental disorders who would access public sector mental health services, which, according to ECA estimates, would be 2% of the adult population in Milwaukee County. Using the above methodology, following are the estimated numbers of adults in Milwaukee County needing public sector mental health services:

Table 3

ADULT TARGET POPULATIONS FOR PUBLIC SECTOR MENTAL HEALTH SERVICES IN MILWAUKEE COUNTY

Group 1: Persons with Severe and Persistent Mental Illness	**4,753**
Group 2: Persons with Severe Mental Illness	**1,459**
Group 3: Persons who were Severely Impaired	**4,996**
Group 4: Persons with Mild or Moderate Mental Disorders	**14,048**

The service recommendations contained in this Master Plan will be based on the use of these four target population groups, with the assumption that people within these groups will have similar service needs. This methodology also assumes that these estimates represent the total number of people in each of these groups at any given point in time. It does NOT imply that an individual cannot change from one service need category to another. These estimates are only meant to be used as tools for planning at the systemic level. In fact, the primary assumption underlying all recommendation within this plan is that continuity of caregiver and service flexibility are at the core of the service delivery system.

THE NATURE OF SEVERE MENTAL ILLNESS

(excerpted from National Advisory Mental Health Council, 1993, p.1449)

The term "severe mental illness" encompasses a group of discrete mental disorders that differ in cause, course, and treatment. No single image captures the functional meaning of severe mental disorders for those struggling with their consequences. The lives of individuals with schizophrenia, manic-depressive illness, or obsessive-compulsive disorder are as varied as their ages, family incomes, service needs, and responsiveness to treatment and rehabilitation. Most of these disorders are long-lasting and produce significant levels of impairment, especially when optimal treatment is not available. This population includes a relatively small group of individuals whose symptoms are largely untouched by currently available treatments or rehabilitative efforts (included as well, are some individuals--such as many homeless people with severe mental disorders--whose disability is exacerbated by long-term lack of treatment, physical illness, and/or substance abuse). This toll continues to diminish, however, as new effective clinical treatment and service approaches become available. But the population of Americans with severe mental illness also includes many more individuals who, with appropriate diagnosis, treatment, and rehabilitation, can lead relatively normal, productive lives in the community.

SERVICE COMPONENTS

The service components proposed for the comprehensive public sector mental health service system for adults with mental illness in Milwaukee County are designed to assist most people with severe mental illness to obtain the outcomes discussed above. Figure 9 displays the specific service components within the overall service system, and the following text provides descriptions of each of the individual service components within the five functional areas (Risk Reduction, Wellness and Rehabilitation, Pre-Crisis Intervention, Immediate Crisis Response and Stabilization, and Inpatient Services), as well as the projected number of people to receive the service (see Table 4), and the proposed revenue shifts. In some cases, however, the component is a system capacity rather than based on specific target population need (e.g., risk reduction programs). For those service components which already exist in Milwaukee County, the descriptions provided in Chapter Two are repeated in this section, along with descriptions of the proposed service components. This provides the reader with a complete description of the comprehensive, integrated service system proposed for Milwaukee County.

When reading this section, it is helpful to understand that revenues, rather than service costs, were used for the fiscal analyses since this information was much more accessible. Often revenues may exceed or be less than actual cost for a particular service; when this occurs, agencies often use excess revenue generated by one service to cover the cost of services which did not receive enough revenue within the fiscal year, or they rely on tax levy funds to balance the revenue/cost ratio. As such, the fiscal analyses in this plan do not reflect actual cost of each service, but rather the revenue generated by this service (including tax levy funds). By using end-of-the-year revenue summaries, the fiscal analyses do reflect total revenues across all services within the public sector system, and the proposed services are based on revenue (rather than cost) reallocation projections. Chapter Five provides a detailed description of the fiscal analysis used to project the proposed revenue shifts.

Figure 9

KEY SERVICE COMPONENTS OF THE PROPOSED PUBLIC SECTOR MENTAL HEALTH SERVICE SYSTEM FOR ADULTS IN MILWAUKEE COUNTY

RISK REDUCTION PROGRAMS	WELLNESS/REHABILITATION SERVICES	PRE-CRISIS SERVICES	CRISIS RESPONSE/ STABILIZATION SERVICES	INPATIENT SERVICES
• Family/ Child Programs, Wellness Education	• **24 Hour Referral/ Triage Telephone #** • **Intensive Community Services Assessment Program** • Short-term Eval/Triage (CCLP)	• **Assist Team**	• **Mobile Crisis Team**	• Mental Health Complex
• Public MH Education/Referral	• CSPs (Intensive Needs) • **Targeted Case Management** • Geropsychiatric Triage • COP • **Benefits Coordination** • **Flexible $ Pool**	• **Warmline**	• **Mental Health Police Liaison**	• General Hospitals
• **Other Identified Needs**	• Housing * Regular Housing with Supports * CBRFs	• **Respite Apt for Clients and Families**	• Hotlines/Crisis Lines	• State Mental Health Institutes
	• Health Management/Alternatives * Home Health Care	• **In-Home Childcare Respite**	• **Crisis Specialists (in home)**	
	• Daytime Activities * Vocational/Occupational/Educational * Psychosocial Clubs/ Drop-In Centers * Day Treatment	• Homeless Outreach Services	• **Crisis Apartment (several days)**	
	• Consumer Support/ Education/Advocacy * **Primary Consumers** * Families	• Jail/Forensic Services	• Emergency Room Walk-Ins (General Hospitals, Psychiatric Emergency Rooms)	
	• Income Management	• Dual Diagnosis Services	• Psychiatric Crisis Services (24 hr evaluation, hospital-based)	
	• Outpatient Clinics * Counseling * Medication Management			
	• Alternative Counseling Services			

NOTE: Proposed new service components are shown above in **bold**. In addition, each of the existing service components is proposed to be either enhanced or decreased.

Table 4
COMMUNITY SERVICES IN PROPOSED PUBLIC SECTOR ADULT MENTAL HEALTH SYSTEM BY TARGET POPULATION

SERVICE COMPONENT	"Unit" Definition	ALL POPULATIONS Proposed # of Clients	TARGET POPULATION 1 N = 4753 Proposed % Targt Pop Needing Svc	TARGET POPULATION 1 N = 4753 Proposed # of Clients	TARGET POPULATION 2 N = 1459 Proposed % Targt Pop Needing Svc	TARGET POPULATION 2 N = 1459 Proposed # of Clients	TARGET POPULATION 3 N = 4996 Proposed % Targt Pop Needing Svc	TARGET POPULATION 3 N = 4996 Proposed # of Clients	TARGET POPULATION 4 N = 14,048 Proposed % Targt Pop Needing Svc	TARGET POPULATION 4 N = 14,048 Proposed # of Clients
RISK REDUCTION SERVICES										
Family/Child Programs	Program	NA	NA	NA	NA	NA	NA	NA	NA	NA
Public MH Education/Referral	Program	NA	NA	NA	NA	NA	NA	NA	NA	NA
WELLNESS/REHABILITATION SERVICES										
Information/Triage Telephone #	Program	NA	NA	NA	NA	NA	NA	NA	NA	NA
Community Assessment Program (CAP)	Program	1,070	42%	395	50%	145	53%	529	0%	0
CCLP (short-term eval/triage)	# clients	400	2%	75	5%	75	5%	225	2%	25
CSP Cert Ind Liv & Sup Apt (excludes WCS CSP)	# clients	4,178	80%	3,503	60%	675	0%	0	0%	0
Targeted Case Management	staff	4,942	14%	670	36%	525	75%	3,747	0%	0
Geropsych Outpt and Triage Prgm	# clients	1,252	5%	233	5%	71	5%	245	5%	702
COP (Admin Staff)	Admin staff	0	(in DHS Admin)		(in DHS Admin)		(in DHS Admin)		(in DHS Admin)	
Benefits Coordination	Admin staff	2,801								
Flexible Resource Pool	# clients	1,346	20%	172	10%	145	5%	250	0%	0
CBRF	# clients	172	4%	172	0%	0	0%	0	0%	0
Home Health Care	# clients	192	0%	48	2%	24	2%	120	0%	0
Day Activities										
Work Programs	# clients	560	5%	237	5%	73	5%	250	0%	0
Community Employment	# clients	810	5%	238	5%	72	10%	500	0%	0
Psychosocial Rehabilitation Prgms	# clients	2,333	25%	1,188	10%	146	20%	999	0%	0
Day Treatment	# clients	606	5%	238	15%	218	3%	150	0%	0
Consumer Support/Edu/Adv										
Primary Consumers	Funding	NA	(in DHS Admin)		(in DHS Admin)		(in DHS Admin)		(in DHS Admin)	
Families	Funding	NA	NA	NA	NA	NA	NA	NA	NA	NA
Income Management										
Protect Payeeships	# clients	100	2%	80	1%	20	0%	0	0%	0
Guardianships	# clients	0	0%	0	0%	0	0%	0	0%	0
Outpatient Services	# clients	4,822	5%	238	5%	73	20%	999	25%	3,512
Alternative Counseling	Program	500	0%	0	0%	0	0%	0	4%	500
PRE-CRISIS SERVICES										
Assist Team	Team	1,121	10%	475	10%	146	10%	500	0%	0
Warmline	Warmline	2,242	20%	951	20%	292	20%	999	0%	0
Respite Apt/House	Apt	160	2%	95	1%	15	1%	50	0%	0
In-home Childcare Respite	Staff	112	1%	48	1%	15	1%	50	0%	0
Homeless Services										
Mobile Community Clinic	Team	361	5%	238	5%	73	1%	50	0%	0
Homeless Health Care	Program	470	7%	333	6%	88	1%	50	0%	0
Jail/Forensic Services										
Non-Certified: CSP	# clients	500	6%	300	14%	200	0%	0	0%	0
Jail Diversion	# clients	1,200	9%	450	34%	500	5%	250	0%	0
Eval/Tx: Hse of Correction	# clients	240	2%	100	7%	100	1%	40	0%	0
Forensic Outpt Eval Center	# clients	695	8%	400	14%	200	2%	95	0%	0
Dual Diagnosis (MI/SA) Services	# clients	1,450	8%	400	17%	250	5%	250	4%	550
CRISIS RSPNSE/STABILIZATION SERVICES										
Mobile Crisis Team	1 Team	871	10%	475	10%	146	5%	250	0%	0
Mental Health Police Liaison	Staff	871	10%	475	10%	146	5%	250	0%	0
Hotline/Crisis Line	Hotline	2,034	20%	951	40%	584	10%	500	5%	0
Crisis Specialists	Program	1,888	20%	951	30%	438	10%	500	0%	0
Crisis Respite Beds/Apt/House	Apt	357	4%	190	8%	117	1%	50	0%	0
Psychiatric Crisis Service	# clients	2,499	15%	713	40%	584	10%	500	5%	702
REVENUES FOR TOTAL COMMUNITY-BASED SERVICES		$52,683,077	$29,289,695		$7,640,946		$10,826,953		$4,925,483	
% OF TOTAL COMMUNITY SERVICE REVENUES			56%		15%		21%		9%	
REVENUE ALLOCATION PER PERSON		$31,587	$6,162		$5,237		$2,167		$351	

RISK REDUCTION PROGRAMS

In FY92, 0.33% of all revenues in the public sector mental health system were allocated to four organizations which specifically focus on risk reduction activities. The activities provided by these four organizations included early intervention services to support high risk families, work-site wellness programs, coping skills education, suicide and depression prevention programs, and education and information directed towards the general public about mental health issues, symptoms, and service resources.

As noted by the Final Report of the Milwaukee County Task Force on Prevention and Early Intervention (1989), providing resources for these kinds of activities are extremely effective in the long-run, in that they can prevent or diminish the probability of individuals developing mental-emotional disabilities in the future. Unfortunately, because these programs do not provide direct services to individuals experiencing a disruptive disability or problem, resources for these activities are often the first to be reduced in times of fiscal constraints. In reality, in order to stop the trend toward higher demands for human services in our society, these risk reduction activities should be protected at all costs.

It is recommended that the revenues for risk reduction activities be increased to $752,349 within the next five years. Under the revenue assumptions of this Master Plan (see Chapter Five), this would result in a 550% increase in tax levy and community aids revenues allocated to these activities by ASD (from $88,452 to $482,463). The remaining revenue amount of the FY92 and proposed totals is revenue collected by the programs themselves (see discussion of Miscellaneous Revenue Sources).

Funded activities should include, but not be limited to, parent education and support; stress management in the workplace and in the home; coping skills for elders, for people with disabilities or medical illnesses, and those undergoing extreme situational stress, and their families; and education in schools and in the general community about mental illness. All of these programs have shown to be effective in reducing risk of future emotional disturbance (National Mental Health Association, 1986). Since mental-emotional disorders involve all aspects of a persons life, it is important that risk reduction efforts be funded and coordinated across all relevant departments and community organizations, such as Education, Youth Services, Aging, Drug and Alcohol, and Health. In addition, in order to continue in times of resource constraint, risk reduction programs must engage in evaluation activities that will provide measures of their effectiveness.

	FY1992	*Proposed*
Revenues:	*$268,376*	*$752,349*

WELLNESS/REHABILITATION SERVICES

The vision of the Milwaukee Mental Health System is that individuals with mental illness will be full and equal members of the community, and that the system shall provide them the support and the means to pursue success in the ways they choose to live, learn, love, work and play. As such, a primary emphasis of the service system should be on having an array of resources that will assist individuals with mental illness to maintain wellness, to acquire or regain skills that assist them to achieve their goals, and to avert the need for intensive crisis or inpatient services. In addition, access to these resources should be coordinated so that the person receives service and supports in a timely and responsive manner, and that they are the appropriate service to meet the person's needs.

The Department on Aging was created as the county's primary service structure and access point for persons 60 years and older and administers programs that deal specifically with the infirmities of aging. The Department on Aging, however, has been given no special mission with regard to the mental health needs of older people. Thus, to insure that older people with mental health needs who may call the Department on Aging have access to specialized mental health services without being lost, the Department's Information and Assistance Unit must have a protocol with the access unit of the proposed Mental Health System.

Figure 10 provides an overview of the functioning of the various components within the proposed service system.

24 Hour Referral/Triage Telephone #

In general, access for any new person needing or requesting services will be available through a 24 hour information and referral telephone line, which will be co-located with the 24 hour crisis line. This model for access and referral is used very successfully in a number of comprehensive urban service systems throughout the United States. Information and Referral Phone Line staff screen calls to assess whether they are routine, in the sense that the person wants information or referral to mental health services, or whether the call concerns someone experiencing a crisis. In essence, this Information and Referral Line is the primary point of access into the public mental health service system, and performs a vital system coordination and integration role (see Figure 10). This telephone line will be staffed by one Masters-level Psychologist/Social Worker or Psychiatric Registered Nurse three shifts a day, seven days a week, and will interact with the Department on Aging Information and Referral Line for persons over 60.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$244,672*

Community Assessment Program

At the core of a good wellness and rehabilitation service system is a primary person or team of persons, on whom the individual with mental illness can rely for support, counseling, assistance with daily living activities, and service access and coordination. The person(s) is also the key information source for overall system evaluation and planning, in terms of being most knowledgeable about client outcomes and service gaps. In Milwaukee County, this service will be provided either through CSPs or through Targeted Case Management services. Access to these resource intensive services will be provided through a Community Assessment Program, designed to screen and refer appropriate individuals to the agencies providing CSP or case management services. Modeled after a program operated by the Franklin County Mental Health Board in Columbus, Ohio, this program will be staffed by 1.75 Clinical Psychologists, RNs and/or MSWs twenty-four hours a day, seven days a week. One of these staff will meet with each individual who has been referred for CSP or case management services, and conduct an interview and diagnostic assessment to determine whether these services are appropriate for the individual. If so, the person will be linked within 48 hours with the CSP or case management provider that can best meet their specific needs. If not, the person is assisted to access other relevant services within the system.

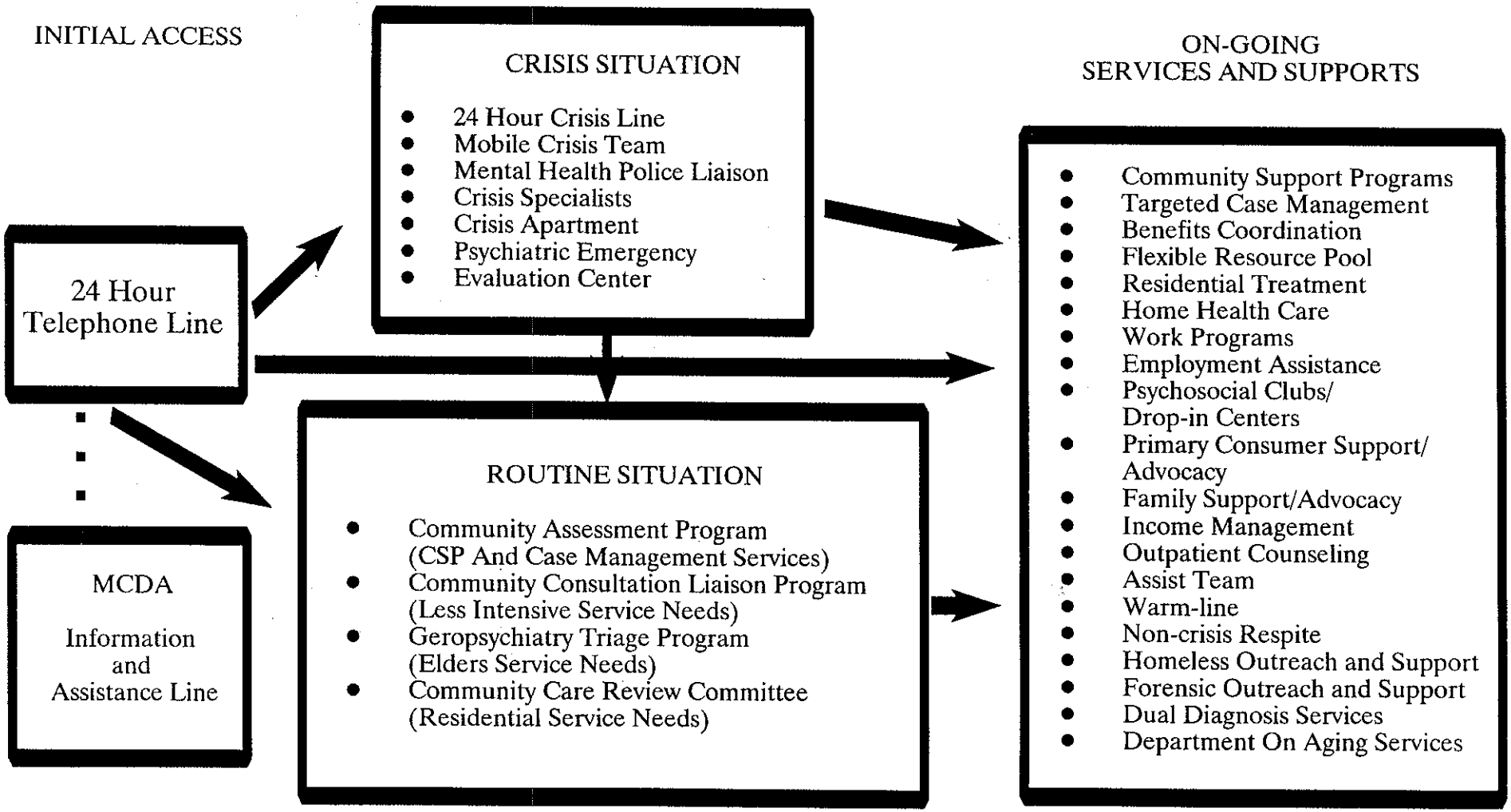
	FY1992	*Proposed*
Revenues:	*$ 0*	*$451,580*
Annual Number Served:	*0*	*1,070*

In addition to the Community Assessment Program (CAP), there will be several other assessment and referral programs to help individuals access appropriate services. These include the existing Community Consultation Liaison Program (CCLP), which provides assessment and triage for people who have less intensive needs than those who need CSP or case management services; the existing Geropsychiatry Triage Program, which provides outreach assessment and triage for elders; and the existing Community Care Review Community, which reviews referrals for residential treatment programs. Each of these triage components has a unique expertise, and will play a vital role in coordinating access to various services to meet individuals' special needs.

Figure 10

FUNCTIONING OF PROPOSED SERVICE SYSTEM

IN VIVO ASSESSMENT AND TRIAGE



t:\ta\chart\assesmnt.cht

Community Consultation Liaison Program (CCLP)

This is a mobile service which provides on-site mental health assessments, short-term interventions, triage to on-going services and programs, and follow-up assessment for individuals who most likely do not need more intensive supports, such as CSPs or case management. This assessment and triage service will primarily focus on the needs of people in Target Group 3 (people who need services to prevent relapse, and who probably are not associated with a CSP or case manager), and will no longer need to respond to crisis situations due to the increase in crisis outreach services. It will continue to be staffed by two full-time registered nurses, and is available from 8 am to 5 pm, Monday through Friday.

	FY1992	*Proposed*
Revenues:	*$ 140,006*	*$140,800*
Annual Number Served:	*398*	*400*

Community Support Programs (CSPs)

CSPs are a standardized set of services, promulgated under Chapter 51, that are designed to provide intensive case management and mobile treatment, rehabilitation, and support services to individuals with severe mental illness. CSPs are based on a case management system which combines advocacy, coordination, system planning, monitoring and support functions, and focus on developing a relationship based on consumer strengths and self-determination, working in the field, and using aggressive outreach methods. Each CSP client has a designated case manager that is responsible for maintaining a clinical relationship with the client on a continuing basis whether the client is in the hospital, in the community, or involved with other agencies (Wisconsin Administrative Code, HSS 63.12). CSPs are required to provide or make arrangements for access to, a comprehensive system of services, including symptom management or supportive (family, group or individual) psychotherapy; psychiatric and psychological services; medication prescription, administration, monitoring and documentation; crisis intervention services; employment related services; social and recreational skills training; activities of daily living support and training; physical health services; legal services; transportation services; benefits access and coordination; and safe and normal housing (HSS 63.11).

Each Community Support Program must have on its staff a director, a psychiatrist and a clinical coordinator, who provides direct supervision of CSP clinical staff. In addition, CSP clinical staff may include CSP professionals (who have a bachelor's degree), licensed clinical psychologists, clinical social workers with a MSW, registered nurses, occupational and recreational therapists, certified rehabilitation counselors, vocational counselors, and paraprofessional mental health technicians (HSS 63.06). The maximum staff to client ratio is 1:20, and at least 50% of service contacts must be provided in the community in non-office based or non-facility based settings. The eligibility criteria for access to CSP services

is very stringent, with a focus on individuals with the most severe needs. In the proposed service system, resources are prioritized to provide CSPs for 80% of persons in Target Groups 1, and 60% in Target Group 2, with the assumption that if these individuals can receive intensive, flexible supports, they will be able to avoid many situations which previously had resulted in the need for crisis or inpatient services.

In addition to general CSPs, it is recommended that several specialized CSPs be developed which have staff with expertise about specific issues. These would include CSPs with specialized services for people who are Homeless, are medically fragile, have Substance Abuse issues, have Developmental Disabilities, are Elders (see Appendix C for interface with Department on Aging), are Hearing Impaired/Deaf, are Transitioning from Youth to adult (ages 18-21), and are Transitioning from Long-term Inpatient Care. (CSP services for people involved in the correctional system are discussed in the section on Pre-Crisis Services.) In keeping with state CSP certification regulations, these specialized teams would not exclude people who do not have these issues, but would be staffed to provide more focused services and supports for individuals who do have these needs. It is recommended that all new CSPs that are developed meet the state CSP certification requirements in order to assure quality and comparability of service across provider agencies, and that they have a lower caseload than the 1:20 maximum ratio mandated by CSP regulations. As such, the projected revenues per person for CSP services will be greater than FY92 revenues due to increased staffing costs to achieve these goals.

	FY1992	*Proposed*
Revenues:	*$3,449,839*	*$18,821,890*
Annual Number Served:	*1,010*	*4,178*

Targeted Case Management

Targeted case managers will be available to assist individuals who do not need the comprehensive services provided by CSPs, but who do need a primary person to assist them with service access and coordination, and also provides some therapeutic support. Specifically, case managers or case management teams provide a set of services which includes identifying the needs and strengths of the individual; developing a service plan with the individual which identifies long-term and short-term goals; assisting the individual to access services; and providing supportive counseling and assistance.

Similar to CSPs, some case management programs may develop specific expertise about certain issues in addition to mental illness (i.e., elders, people who are homeless, and people involved in the judicial system). Unlike the CSPs, however, which are designed to be comprehensive service programs, case managers will coordinate with other service components to help the person meet their needs and achieve their goals.

Case management services are available 24 hours/day, 7 days a week, and have a maximum caseload of 1:50. This staffing ratio is based on the assumption that case managers will provide services to people with varying ranges of need, in that 14% of the people in Target Group 1, 36% of Target Group 2, and 75% of people in Target Group 3 are projected to need this service.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$4,257,000*
Annual Number Served:	*0*	*4,942*

Geropsychiatric Triage

The Geropsychiatric Triage Program is staffed by a multi-faceted team of geropsychiatrists, geropsychiatric nurses, psychologists and social workers who coordinate medical, mental health, and social service resources to maintain the individual in the community whenever possible. It is an integral and valued resource within the existing service system for elders with mental health needs (see Appendix C). As such, it is recommended that this service component be available to serve approximately 20% more people by the end of the five year period.

	FY1992	*Proposed*
Revenues:	*$734,900*	*$882,660*
Annual Number Served:	*1,043*	*1,252*

There will be a variety of direct services available to individuals in the four target groups. These include Benefits Coordination; a Flexible Resource Pool; Residential Treatment Programs; Home Health Care; Work Programs; Employment Assistance; Psychosocial Clubhouse Programs; Drop-in Centers; Family and Consumer Self-advocacy Peer Support, and Education; Income Management Assistance; Outpatient Counseling and Medication Management; paraprofessional Assist Team; Warm-line; Non-Crisis Respite; and Outreach and Support Services for people who are Homeless, who have forensic involvement, who have substance abuse issues, and who are elders. These services can be accessed by directly contacting a provider agency or by getting referrals from one of the assessment and triage components discussed above.

Community Options Program (COP)

This funding program assists people with severe mental illness who live in Institute for Mental Disease/nursing homes or are at risk of entering such facilities, who generally do not have support systems, are receiving limited financial assistance, and are unable to access community resources for a variety of reasons. COP funding provides long-term support to enable them to live at home or in community-integrated settings and to have ready access to generic community resources, such as shopping, money management, and medications monitoring. In FY92 , the program was administered by the Mental Health Complex; however, it is recommended that this function shift to the proposed Contract, Planning and Evaluation Bureau (see later discussion on Administrative Structures and Other Supports).

	FY1992	*Proposed*
Revenues (for services):	*$821,992*	*$821,992*
Revenues (Admin staff):	*$139,325*	*$139,325*

Benefits Coordination

Due to the lack of case management or needed CSP services, individuals with mental illness in Milwaukee County traditionally have not received focused assistance with accessing entitlements or other benefits. In response to this need, the Housing Follow-Along service was developed to assist persons being discharged from inpatient stays to access entitlements and appropriate housing upon discharge, and new resources have been approved in the FY94 budget process to increase this service over the next five years. In addition, new resources also have been approved to hire two benefits specialists to help individuals access entitlements.

With the proposed increase in CSP and case management services, it is recommended that the Housing Follow-Along resources be allocated to CSP services, since they will perform this function for individuals discharged from inpatient services. However, the Benefit Specialists positions should remain as an independent resource for those people who did not receive services from a CSP.

	FY1992	*Proposed*
Revenues:	*$unavailable*	*$90,000*
Annual Number Served:	*152*	*2,801*

Flexible Resource Pool

Many states and localities have found that consumers' success in the community is often dependent on having access to resources for necessities which are not paid for through traditional mental health programs or funding streams, such as rent or telephone deposits, rent subsidy, transportation, medication, personal items, utility deposits, and so forth. Case managers have found that having access to a flexible pool of money for such needs is very cost effective, in that it can often help avert a situation which might result in crisis, or provide the small amount of financial support that enables inpatient discharge or independent living. As such, it is recommended that a flexible resource pool be created which would be available to individuals for necessary expenses that are critical to successful community living, but that are not paid for through mental health programs. This flexible pool would be accessible by CSPs or case managers, on behalf of an individual with mental illness, and would be administered by the Contract, Planning and Evaluation Bureau. The new $10,000 revolving loan fund, made available through the recent Lawsuit Settlement, would be a part of this flexible resource pool.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$403,800*
Annual Number Served:	*0*	*1,346*

Housing and Residential Treatment Programs

It is recommended that Milwaukee County emphasize the development of regular housing with supports, which is the preferred living situation of people with mental illness throughout the United States, and in Milwaukee County. This approach assists individuals to access safe, affordable housing (apartments, cooperatives, houses) of their choice, with CSPs or case managers providing the necessary supports to ensure that they maintain their chosen housing, and that landlords are given the assurances and supports that they need.

Most of the costs for this approach are contained within the costs of the other service components. However, there is a need for a Housing Specialist within proposed Adult Mental Health Division to focus on low income housing development and access for adults with mental illness. This person would focus on aggressive grant writing, use of preference list for Section 8 Voucher allocation, advocacy and joint planning with the Housing Authority and local landlords, and so forth. Other administrative agencies throughout the country have hired such a specialist with great success for increasing the availability of low income housing for people with mental illness. Revenues for such a position have already been identified by the Adult Services Department, and this position included in the section on Administrative Structures and Other Supports.

CBRFs are residences, staffed 16 hours a day in Milwaukee County, which provide a structured living environment and services to enable the person to function more independently and/or transition to a less restrictive community setting. CBRF services include supervision, dietary counseling, medication monitoring, financial management, social activities, and vocational guidance. However, often these residential programs lose their treatment focus, and instead become a housing arrangement for people who once had more intensive treatment needs.

It is recommended that the use of CBRFs be diminished over time, as more CSP services become available, and that the mission of CBRFs be focused to provide specialized treatment services for groups of individuals with treatment needs who could benefit from a group residential treatment setting, with the goal of assisting the individual to return to their own living situation as quickly as possible. In addition, within this effort, County CBRF policy needs to be changed to make them less restrictive and more accommodating. For example, the County policy that consumers to be involved in a structured day activity in order to access residential programs needs to be revised, as does the county policy that persons served in CBRFs cannot also receive services from CSPs or case management.

It is recommended that the Adult Family Care Home program, which places people in family homes and provides case management and support for the family caring for the individual, be eliminated, and that these individuals receive services through other components of the proposed system.

	FY1992	*Proposed*
Revenues:	*$5,442,451*	*$3,820,808*
Annual Number Served:	*269*	*172*

Home Health Care

Access to good medical care is a vital component of a comprehensive mental health system, in that physical health issues often are masked by the more predominant symptoms of mental illness. In addition, medical care must be available through outreach services, since the combination of a person's physical and mental health issues may prohibit them from going to an office setting. In FY92, approximately 585 people with mental illness received home-based health care from Home Health Agencies through a Medicaid waiver approved by the State Bureau of Health Care Financing. The types of services provided during home health care visits include physical health problem management, medication management, hygiene assistance, disease process management/therapeutic intervention, diet/nutrition counseling, service coordination, risk factor management, and skills teaching. As the Master Plan is implemented, CSPs and Case management will ensure that most individuals in Target Groups 1 and 2 have access to adequate health and dental care services, and that they receive medical assistance benefits that they are entitled to. There also will be one or more specialty CSP teams to serve persons who are medically frail. For those individuals not receiving case management or CSP services, and who are home-bound, Home Health

Care Services must be available. In addition, every effort should be made to ensure that home-bound people with mental illness who are medically frail receive home health services.

	FY1992	Proposed
Revenues:	*$ 0 **	*$119,808*
Annual Number Served:	*585*	*192*

* Approximately $2,000,000 funded these services through a Medicaid Waiver which was not administered by the Department of Human Services, and thus, is not included in the revenue accounting in this plan.

Daytime Activities

All persons with mental illness need to have access to meaningful daytime activities of their choice. In addition to the vocational assistance provided to persons receiving CSP services, programs need to be available which provide vocational services and employment opportunities, educational opportunities, psychosocial rehabilitation clubhouse programs, and therapeutic day treatment programs. In addition, individuals should be assisted to access other daytime alternatives available in the community, such as programs for elders.

Work Programs: These services provide paid work in rehabilitation facilities to assist individuals in understanding the meaning, value and demands of work, modify work behavior, and provide vocational development.

	FY1992	Proposed
Revenues:	*$ 554,905*	*$1,775,760*
Annual Number Served:	*175*	*560*

Community Employment: These services are targeted to individuals who desire competitive employment, and consists of a range of services to help the person secure community employment and provide support and supervision at the job site to help assure job retention. Services include vocational assessment and counseling, pre-vocational job readiness, career development, job development, on-the-job training, and support provided to the consumer, as well as the employer. This service also includes a variety of support services to the consumer, including assistance with transportation, grooming, practicing for job interviews, side-by-side support on the job, and so forth.

Vocational Services includes both transitional employment and supported employment components. Transitional Employment provides opportunities for individuals to work on job placements in business and industry on a part-time, time-limited basis, and at prevailing industry wages. Supported Employment Services help individuals locate employment and provides them with the supports necessary to maintain their jobs, including transportation training and on-site job skills training. As the person gains competence in the position, on-site support is gradually withdrawn.

	FY1992	*Proposed*
Revenues:	*$315,244*	*$2,579,040*
Annual Number Served:	*99*	*810*

Psychosocial Rehabilitation Clubhouse Programs/Drop-in Centers: For those individual who do not yet desire vocational opportunities, psychosocial rehabilitation clubhouses will be available to help them achieve or regain the confidence and skills necessary to lead vocationally and socially productive lives. Clubhouses have members as their participants, and membership is voluntary and not time-limited. Members choose the way they use the clubhouse, and staff and members work side by side in running the club. Such activities include helping with the operation and enhancement of the club, typing, ordering supplies, shopping, cooking, cleaning, gardening, answering the phone, tutoring, writing, and editing a newsletter. Social and recreational activities also are often organized by the members.

Drop-In Centers, which are consumer-operated centers that provide a place to meet other consumers of mental health services through structured and non-structured social and recreational activities, also should be expanded from the one program that exists.
These centers are places where consumers provide each other with needed social and emotional support, and also serves as a central location to gain access to information about good services or needed advocacy activities. Drop-in centers frequently provide organized peer support groups and peer counseling activities. Frequently the centers are open during evening and weekend hours. Transportation is provided to assist people to access this service. They have found to be a very beneficial component within comprehensive systems for persons who tend to dislike more formalized services and activities.

	FY1992	*Proposed*
Revenues:	*$280,065*	*$3,350,188*
Annual Number Served:	*195*	*2,333*

Therapeutic Day Treatment: These services consist of therapeutic daily activity in a structured and supervised environment, to assist a person to return to his/her previous level of functioning. It provides short-term, high activity alternatives to hospitalization, with a primary emphasis on addressing symptoms or functional issues which prohibit the person from engaging in less restrictive and intensive daytime activities.

Day treatment programs have been the primary daytime activity service available to persons with mental illness. It is recommended that the existing day treatment services receive assistance to change to a psychosocial rehabilitation model, which has found to be more effective for providing rehabilitation services for people with mental illness, and that some medical day treatment services remain to focus on individuals with more intensive, short-term therapeutic needs.

	FY1992	*Proposed*
Revenues:	*$4,056,867*	*$2,617,920*
Annual Number Served:	*939*	*606*

Consumer Support/Education/Advocacy

Primary Consumers: This component is a key piece of any responsive and relevant service system, and is addressed in more detail in the section on Administrative Services and other Supports. Resources should be available to assist persons with mental illness to develop peer support activities, educational programs, encouragement to become involved in service system advocacy, planning, policy development, implementation and employment, and so forth. A such, it is recommended that a Consumer Affairs Specialist (who has a diagnosis of mental illness and has had experience using public sector mental health services) be hired in the proposed Contract, Planning and Evaluation Bureau to support the development of these activities throughout the County. In addition, resources are contained within this organizations' proposed budget to facilitate this purpose.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$100,000*

Families: Resources for family education, support and advocacy are also a vital component of a comprehensive service system. Services provided include a monthly educational program, a monthly newsletter, family support group meetings, a reference library, public education activities to combat stigma, legislative and governmental advocacy, a housing assistance program, and a protective payee program assisting 33 people (see below). It is recommended that the support for organizations which provide such services for family members of individuals with mental illness be increased to encourage family involvement in the service delivery system as much as possible.

	FY1992	*Proposed*
Revenues:	*$29,720*	*$80,000*

Income Management

CSPs and case management services will assist persons to apply for entitlements and manage payeeships when needed. For those persons not served by CSPs or case management, Individuals who need assistance learning to manage their monetary resources will have access to a Representative Payee. The goal of this relationship will be ensure that resources are used to provide for necessary, basic supports, while at the same time working with the individual's case manager to teach the consumer money management skills.

In addition to the protective payee program for 33 people mentioned above, ASD contracted with two community agencies in FY92 to specifically assist individuals with income management activities. One of these organizations provided representative payee, financial counseling, and money management services to 25 individuals. A second organization provided corporate guardianship services for 17 people found incompetent and in need of a guardian. It is recommended that mechanisms be developed to help people control their limited resources more effectively, including the provision of more protective payees, training in money management skills for consumers, and attention to this issue by case managers with their clients.

	FY1992	*Proposed*
Revenues:	*$65,153*	*$169,400*
Annual Number Served:	*42*	*100*

Outpatient Clinics

These in-office appointments include individual or group counseling, and medications and medication monitoring (medication assessment, prescription, and review provided by a psychiatrist or a nurse). Medication services also include educating the person and/or family about the effects of the medication, and of any potential side effects.

In FY92, MHC operated six outpatient clinics geographically distributed throughout the county, which served a total of 8,073 people. In addition, ASD provided funds to three private general hospitals (Sinai-Samaritan, St. Michael and Children's) for outpatient services received by 1,322 adults with mental illness who needed fee reimbursement assistance. In essence, outpatient clinics provided the primary service to address the clinical needs for most people with mental illness in Milwaukee County. However, with the increase in CSP and case management services for people in Target Groups 1 and 2, it is projected that fewer people will need outpatient clinic services, and they should primarily be targeted to individuals in Target Populations 3 and 4.

Persons in Target Group 3 are not recently severely impaired but have been severely impaired in the past and need services to prevent relapse. Those in Target Group 4 are typically individuals who are experiencing short-term situational distress that is disrupting their day-to-day functioning due to the emotional stress (e.g., experiencing divorce, job loss, loss of a loved one) or those whose lives are extremely stressed by the combined effects of poverty, violence and drug abuse, and that present at mental health services with exacerbations of mental disorders due to these stresses or acute emotional reactions to interpersonal conflict or disruption. As such, even though these individuals do not have a severe mental illness, as defined by diagnosis, disability and duration, they do need services to avert more severe problems in the future.

	FY1992	*Proposed*
Revenues:	*$9,069,108*	*$4,653,230*
Annual Number Served:	*9,395*	*4,822*

Alternative Counseling

ADS provided support to one community-based agency in FY92 which provided short-term counseling services, using non-traditional counseling approaches, to approximately 500 individuals with mental disorders, most of whom did not have a diagnosis of severe mental illness. It is recommended that this service continue to receive the same level of support.

	FY1992	*Proposed*
Revenues:	*$158,410*	*$158,410*

PRE-CRISIS SERVICES

In addition to assisting individuals to maintain wellness, some services are focused specifically on recognizing when an individual may be developing either environmental or physical problems which might result in increased symptoms, and if not attended to, ultimately, the need for intensive crisis intervention services. In such cases, they attempt to address the issue before it develops into a more serious situation. A number of services already discussed also perform the role of supporting someone in this situation (e.g., CSPs, case management, home health care, outpatient clinics). However, more targeted services also need to be developed for this purpose, including an Assist Team, a Warmline, non-crisis Respite Services, and services for people who are homeless, who have involvement with the correctional system, or who have issues with substance abuse as well as mental illness.

Assist Teams

An Assist Team will be staffed by two paraprofessionals two shifts a day, seven days a week to provide additional assistance to case managers when they cannot meet the needs the individuals they serve due to increase demand by one or more clients. This component has proved very effective in dealing with situations so that they do not escalate into ones that may result in a crisis.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$202,578*
Annual Number Served:	*0*	*1,121*

Warm Line

A consumer-staffed telephone "warm" line will be available during evening hours and weekends for consumers who feel alone, scared or anxious, and need to speak with a supportive person. These persons do not need the more intensive services provided through a 24-hour crisis telephone line. Warm line services provide telephone assistance to individuals who need primarily social support which, if ignored, typically results in more serious psychiatric crises.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$85,000*

Respite Apartment for Clients and Families

Modeled after a similar program in Philadelphia, a respite apartment or house will be available for consumers to access for short periods of time if they need to leave their current living environment in order to address the presenting problem. This will be a low demand, voluntary program providing a range of recreational and leisure activities, meals, private bedrooms, supportive counseling, and family crisis relief. One on-site staff will monitor medication and daily living needs, with a respect for the consumers' desires. It will have a maximum stay of 7 days, and will be on first-come, first serve basis.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$180,838*
Annual Number Served:	*0*	*160*

In-Home Childcare Respite

The issue of parenting by persons with mental illness has been almost completely neglected by mental health systems. Almost all housing and residential services are geared for single individuals, and very few resources are available, other than intervention by social welfare, to assist with children when the parent needs to leave home for mental health treatment (for outpatient or inpatient services). As a result, many parents who have mental illness are separated from their children when it may not have been necessary, or in the best interest of either parent or child. A recent state study found that CSP clients in Milwaukee County had a total of 233 children, of which only 90 lived with their parent. Although there could be a variety of reasons for these separations, it does indicate the vital need to be aware of these issues and to provide supports for children to remain with their parents.

Staff throughout the Milwaukee mental health system must be made aware of this issue, so that they may begin to incorporate it into the services that they provide. This is especially true for CSPs, case management, crisis and inpatient services. In addition, a pool of money will be available to provide for child care if a parent with mental illness needs a time of short separation from their child(ren) in order to avert a more serious situation. This childcare can be provided in the child's home or out of home, depending on the need of the parent.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$70,000*
Annual Number Served:	*0*	*112*

Homeless Outreach Services

Mobile Community Clinic: In FY92, two programs were funded specifically to provide services to individuals who were homeless and mentally ill. The Mental Health Complex operates a mobile community clinic, which is staffed by registered nurses and a psychiatrist, and provides a variety of services, including assessment, consultation referral to other service providers, assistance in meeting basic needs, medication prescription and monitoring, long-term psychiatric follow-up, case management for people waiting to get into a community support program, and crisis intervention. It is recommended that this service be expanded to serve additional people in need.

	FY1992	*Proposed*
Revenues:	*$unavailable*	*$300,000*
Annual Number Served:	*unavailable*	*361*

Homeless Health Care: In addition, ASD provided funds to a health care organization to provide medical and community living assistance for 468 individuals who were homeless and mentally ill. It is recommended that this service continue to be supported.

	FY1992	*Proposed*
Revenues:	*$268,297*	*$268,297*
Annual Number Served:	*468*	*470*

Jail/Forensic Services

Non-certified CSP: In FY92, this program assisted 228 people with mental illness who were also involved in criminal proceedings. It provides screening and evaluation services, treatment and probation negotiations with the court, medication monitoring, and helping to meet people's basic needs for food, shelter and income during and after their forensic involvement. This service functions similarly to a CSP, but does not use MSW staff as extensively as required by the CSP staffing standards. This is highly valued program which needs to be expanded to meet the needs within Milwaukee County.

	FY1992	*Proposed*
Revenues:	*$786,978*	*$1,726,000*
Annual Number Served:	*228*	*500*

Jail Diversion Program: This program identifies people with mental illness who are coming interfacing with the criminal justice system, and attempts to divert them from full involvement through triage to appropriate mental health services. This also is an highly valued, cost effective program which needs to be expanded to meet the needs within Milwaukee County.

	FY1992	*Proposed*
Revenues:	*$15,274*	*$18,000*
Annual Number Served:	*1,000*	*1,200*

Evaluation and Treatment Services, House of Corrections: ASD contract for assessment, medication assistance, and counseling services for people with mental illness who are in the Milwaukee County House of Corrections, which is a short-term (one year or less) detention facility. It is expected that the demand for this service will remain constant.

	FY1992	*Proposed*
Revenues:	*$109,180*	*$109,180*
Annual Number Served:	*240*	*240*

Forensic Outpatient Evaluation Program: This Program, which is located at the County jail, offers court consultation, outpatient evaluation of psychiatric status in individuals charged with criminal acts, evaluations for civil commitment proceedings and consultation concerning jurisprudence and public policy information. It is expected that the demand for this type of service will remain constant.

	FY1992	*Proposed*
Revenues:	*$444,078*	*$444,077*
Annual Number Served:	*695*	*695*

Jail Services: At any given time, there are as many as 80 to 100 inmates in the Milwaukee County Jail who receive mental health services. There is a Special Needs Unit for approximately 21 inmates with mental illnesses and a Step Down Unit for less severely ill people which houses about 19 inmates. In addition, there are another 40 to 50 people throughout the institution who are receiving mental health services. Most of the people have a prior history of mental illness and need medications and support. It is estimated that at least 15% of the total jail population has serious mental illness. There is a team of a part-time psychiatrist, nursing, and nine social work staff providing ongoing, active mental health services within the jail. These mental health services are funded by the Milwaukee County Sheriff's Department, and, as such, these services must be included in any long-term planning discussions.

Dual Diagnosis Services

In FY92, MHC operated a program which provided outpatient services to 727 individuals who abused alcohol, as well as drug-free individuals who were addicted to drugs, but who, with counseling, were judged able to maintain themselves without drugs. This program, which focuses on maintaining abstinence, social readjustment, and vocational rehabilitation, was originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, it has developed into a program which mainly serves persons with a primary disorder of substance abuse, due to the lack of services within the County for these individuals. In FY92, this program served, on average, 19 people per working day.

People with mental illness and concomitant substance abuse problems are becoming a primary focus for many mental health systems around the country, and there is an acknowledged need for attention to this matter in Milwaukee County. Since there are no services available to serve people with this dual issue (mental illness and substance abuse) in Milwaukee County, it is strongly recommended that the resources for the substance abuse outpatient program be focused to specifically address the needs of people who have both mental illness and substance abuse issues. In addition, one or more specialized CSPs should

be developed to assist persons with this dual disorder, and training on this issue should be made available for all staff. A joint Task Force should be convened by the Adult Mental Health Division and the Alcohol and Drug Abuse Bureau to make specific recommendations about other service needs of these individuals, such as pilot projects using multi-disciplinary teaming across programs. The Alcohol and Drug Abuse Bureau also needs to develop services to serve persons whose primary issue is substance abuse.

	FY1992	*Proposed*
Revenues:	*$322,847*	*$643,800*
Annual Number Served:	*727*	*1,450*

CRISIS RESPONSE/STABILIZATION SERVICES

The services in this category are available to assist an individual when their situation has escalated to the point that they need immediate intervention to assess the problem and develop mechanisms for resolution. There are several different options for accessing this type of assistance: a mobile crisis intervention team to respond to a situation on an outreach basis; assistance from the Mental Health Police Liaison; "walking in" to the general hospitals' emergency rooms or the specialized psychiatric emergency rooms; or calling a twenty-four hour hotline. The role of each of these services is to assess and try to diffuse the immediate situation, and then triage to back-up support services (crisis specialists or crisis respite apartment) or less intensive services (e.g., Pre-Crisis Services), if possible, or more intensive services (Crisis Stabilization Services), if needed.

Once a person has accessed immediate crisis response services, and it has been determined that their situation cannot be adequately addressed through triage to less intensive pre-crisis or wellness services and supports, they will have access to crisis stabilization services. These services provide short-term (usually 24 to 48 hour) interventions that focus on timely, accurate assessments of the issues which have led to the crisis, good clinical diagnoses and evaluations, and triage with necessary follow-up services. Again, every effort is made to avert the need for more intrusive inpatient stays. Crisis stabilization services in Milwaukee County will be available to be provided in the person's home, in a respite situation, or in a clinical setting.

Mobile Crisis Team

The mobile crisis team provides outreach-oriented crisis response and resolution services for individuals in non-traditional settings. It is available 24 hours a day, seven days a week. Intervention often is provided in consumers' homes, with the Team conducting a clinical assessment of the individual and the situation, making recommendations and triaging for medications and further treatment or problem resolution (in conjunction with the person's case manager, if they have one) and often becoming a mediator and support system for families in times of crisis. Additionally, the team will work cooperatively with the Police when called into an emergency situation to help divert the situation from becoming one which might result in involuntary commitment (see below). The Mobile Crisis Team will be staffed by two Masters level clinicians and one Psychiatric Registered Nurse, as well as have a Psychiatrist on-call.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$824,723*
Annual Number Served:	*0*	*871*

Mental Health Police Liaison

In Milwaukee County, the police are the interface between the person in crisis and access to psychiatric emergency services. In FY92, 4,774 Emergency Detentions were filed by the Milwaukee County Police Department. The average call took 3.3 hours to handle with a two person squad, and typically involved responding to the initial call, assessing whether the situation fit the Chapter 51.15 S.S. criteria for emergency detention (dangerous to self or others), and if so, transporting the person to the Psychiatric Crisis Service for assessment and evaluation, and completing the relevant paperwork for the emergency detention. However, police have little training or understanding of the effects of mental illness, or how to assist someone in crisis. As such, the only available response is to transport the individual to the Psychiatric Crisis Service without any attempt at crisis resolution or triage. This situation creates a large burden on the county's multiple police departments which decreases their overall availability to their communities; has the effect of "criminalizing" mental illness which perpetuates the stigma associated with this disorder; and is very disruptive and clinically detrimental for persons who are experiencing heightened psychiatric symptoms.

The proposed service system will have several mechanisms to address this issue. First, there will be 24 hour availability of a mental health professional, trained specifically in crisis intervention, assigned to the Milwaukee City Police Department to respond with the police to a person's mental health crisis when threatening or dangerous behavior may initially be involved. This Mental Health Police Liaison will be piloted with the Milwaukee City Police Department, since it is the largest of the county's districts and is the primary urban area.

Over time, it is expected that the community will learn to call the 24 hour hotline or the 24 hour referral line, rather than the police department, during times of crisis. The police Liaison would then be accessed by these telephone services when the situation potentially involves crime or dangerous behavior. Also, it is expected that the county's police departments will develop a good relationship with the Mobile Crisis Team (see below), and will access this team when they respond to a call that does not involve criminal activity.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$824,723*
Annual Number Served:	*0*	*871*

Hotline/Crisis Line

There will be a well-publicized toll-free telephone number, with staff available 24 hours/day, seven days/week, to receive calls from people experiencing psychiatric distress. The staff will then access whatever crisis response service seems appropriate for the situation. Although it will be advertised as the number to call when in crisis, the mental health professionals staffing this line may receive calls that are not crisis-related, in which case they will refer the person to the 24 hour referral line which will assess the situation and access whatever service seems most appropriate to address the specific need of the person calling (e.g., CSP or case manager, if the person already has this service; CCLP; Home Health Care; Warmline; and so forth).

	FY1992	*Proposed*
Revenues:	*$unavailable*	*$244,672*
Annual Number Served:	*0*	*2,034*

Crisis Specialists

A team of crisis specialists, who are specifically trained in psychiatric crisis intervention and stabilization, will be available to assist individuals in their own home as long as is needed to intervene successfully in the crisis (typically not more than 3 days). Usually only one crisis specialist is needed for an individual situation, although they may call on other resources (e.e., Assist Team, CCLP, Warm Line, Home Health Care) when needed.

The focus of the Specialist will be to initiate necessary immediate services, resolve problems, provide high levels of support, and make arrangements for ongoing services, always coordinating with the person's CSP or case manager, if appropriate.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$347,276*
Annual Number Served:	*0*	*1,888*

Crisis Apartment (several days)

Respite services are intended to provide a safe environment and staff support for individuals who cannot stay in their homes during a crisis, and who otherwise might be hospitalized. The Respite Service staff will perform the same functions as the Crisis Specialists. Milwaukee County will have three crisis stabilization beds in a residence or apartment, with 24 hour staffing.

	FY1992	*Proposed*
Revenues:	*$ 0*	*$180,838*
Annual Number Served:	*0*	*357*

Psychiatric Crisis Evaluation Service

People experiencing symptoms of mental illness may go directly to the local general hospital emergency room or to psychiatric hospital emergency rooms. In a well functioning mental health system, this hospital-based service should focus on providing twenty-four hour evaluation and triage for further treatment for individuals who require intensive medical intervention or who are exhibiting behaviors that may be acutely dangerous. If the person does not need facility-based assistance, the above crisis services or other community-based services can be accessed.

This is the primary service available for people in crisis in Milwaukee County, and is the service used by police officers for emergency detentions in Milwaukee County. In FY92, 8,707 individual adults used the MHC Psychiatric Crisis Service; of these, 15% (1,304) were seen by this service twice, and 11% (933) were seen three or more times in the year. At the extreme, 58 individuals were seen 10 or more times in FY92, with a range as high as 59 times. In total, PCS had 13,456 "visits" in FY92. However, it is expected that as the other service components are developed within Milwaukee County, the number of people needing this service will reduce dramatically.

To facilitate this change, it is recommended that the first new CSPs to be developed during Plan implementation focus on serving persons who have a history of high use of this crisis service and on those who are discharged from inpatient services.

	FY1992	*Proposed*
Revenues:	*$ 4,477,318*	*$1,284,486*
Annual Number Served:	*8,707*	*2,499*

ADULT INPATIENT SERVICES

Public sector inpatient services for adults with mental illness in Milwaukee County are primarily provided by MHC, although some ASD resources are allocated to inpatient services for individuals with mental illness in nursing homes or the State Institutions. In addition, psychiatric inpatient services are provided by private general hospitals throughout Milwaukee County.

There is no focused role for inpatient services within the mental health system in Milwaukee County. As a result, MHC has traditionally functioned as the primary resource to address intensive needs. There is an open intake gate, resulting in a large number of adult acute admissions each year (2,683 in FY92). In addition, the average daily census for MHC adult psychiatric units (acute and rehabilitation) in FY92 was 567 (80 beds / 100,00 adult population), which is much higher than many of the "model" urban mental health systems in the country. Patients in both the acute and rehabilitation units also often have longer lengths of stay (LOS) than may be necessary, due in part to the unavailability of rehabilitation beds for people from acute units, inadequate resources for discharge planning from both acute and rehabilitation units, and system values focused on client maintenance rather than growth. Although the LOS for the majority of patients on the acute units for the first quarter of FY93 was between 20 and 23 days, on any given day, 50 or more had a LOS of greater than 45 days and some had a LOS of over a year. Many people in acute and long-term placements could be discharged, but several factors prevent this: inadequate community services; limited resources dedicated to coordination between inpatient and community services for individual patients; and inadequate resources for linkage with public benefits. This over-reliance on inpatient services not only affects client outcomes, but also results in low staff morale within the inpatient service system. Implementation of the recommendations of this plan should result in more focused utilization of inpatient services, in that inpatient programs should only be used to provide high quality care to address specific clinical issues for individuals which cannot adequately be addressed in the community. In addition, length of stay, especially in the rehabilitation units, should decrease due to much more focused service provision. As such, efforts will need to be made to provide specialized clinical training for inpatient staff and emphasis placed on state-of-the-art clinical services; this, in turn will create an atmosphere of high energy and motivation around positive consumer outcomes. In addition, joint admission and discharge planning between inpatient and community staff is vital to achieving these positive consumer outcomes.

MHC is undergoing a down-sizing effort which is expected to be completed by May, 1994. Table 5 presents an overview of the FY92, May 1994, and proposed inpatient service capacities, across the service categories described below.

The proposed maximum capacity of 245 inpatient beds was based on several factors. First, MHC inpatient direct service staff attended a training where the concept, functioning and service components of a comprehensive service system were described. After the presentation and discussion, the staff most familiar with each person in a 10% random sample of inpatients were asked to indicate the individual's need for inpatient services, given that a comprehensive system were in place. The assessment procedure yielded three sample subgroups: 1) those who could leave the complex today (36.9%), 2) those who could leave the complex if a comprehensive service system were in place (27.7%), and 3) those would require additional support needs (35.4%). The specific support needs identified for the "non-discharge" clients included secure placement with supervision (78%), money for basic living and housing (70%), help with medication, including opportunity to try Clozaril (65%), community/family acceptance of community placement (48%), additional training for service providers about the person's special needs (22%), and lifting legal/court restrictions re:discharge & placement (13%).

In sum, almost two-thirds of this sample were estimated by MCMHC staff as appropriate candidates for community placement, given the existence of a comprehensive service system, and more than a third appropriate for placement even without a comprehensive service system. Given the representativeness of this sample, this implies that two thirds of the residents of MCMHC could function in the community with a comprehensive community support service system in place, leaving approximately 224 people who need inpatient care at any given time.

The recommendation of a maximum of 245 inpatient beds was also derived by consulting with two nationally recognized experts on inpatient services, who visited Milwaukee County during the course of this project: Dr. Tom Fox, Medical Director for the New Hampshire Department of Mental Health, and Pablo Hernandez, Las Vegas Medical Center Hospital Administrator. It should be noted that the proposed capacity results in a capacity of 34.4 beds per 100,00 adult population, which is still higher than that achieved by "model" comprehensive systems in the country. It also should be noted that this recommendation is not only based on a rationale of effective resource allocation, but more importantly, on providing proactive services and supports to each citizen of Milwaukee County who has a mental illness so that they do not need as much intrusive, facility-based care.

Table 5

CURRENT AND PROPOSED ADULT MENTAL HEALTH INPATIENT CAPACITIES *

	FY1992 CAPACITY	MAY, 1994 CAPACITY	PROPOSED CAPACITY
GENERAL ACUTE STABILIZATION	96	96	60
ACUTE: GEROPSYCHIATRIC	48	48	24
DUAL DIAGNOSIS (MI/SA)	55 **	66	24
DOYLE HOSPITAL UNITS	48	48	48
REHABILITATION	320	192	84
WESTVIEW NURSING HOME	4	4	0
WISCONSIN STATE INSTITUTES	4	4	5
TOTAL ADULT MH INPATIENT BED CAPACITY	575	458	245
TOTAL/100,00 ADULT POPULATION = 712,741	80.7	64.3	34.4

* Does not include inpatient beds for children and youth or persons with developmental disabilities

** Represents an average bed capacity for FY92

Acute Adult Services

The Acute Adult units at MHC provide inpatient care to individuals over age 18 who need short-term hospitalization, and are intended to focus on providing therapeutic activities to motivate and prepare patients for employment and release from the hospital to other facilities or to live at home. In FY92, there were 4 general acute units at MHC, with a total bed capacity of 96. There also were two 24-bed Geropsychiatry units designed to provide services to people over 60. Together, these units had 2,683 total admissions in FY92, and served a total of 2,234 unduplicated individuals, with an average length of stay of 21.22 days. This latter number is deceiving, however, in that although the LOS for the majority of patients on the acute units for the first quarter of FY93 was between 20 and 23 days, on any given day, 50 or more had a LOS of greater than 45 days and some remained for over a year.

Doyne Hospital - MHC Site Inpatient Services

Doyne Hospital (formerly Milwaukee County Medical Complex) operates two 24-bed general hospital-based acute adult psychiatric units located geographically at Milwaukee County Mental Health Complex, which served 739 unduplicated patients in FY92. Unlike the acute adult beds described above, these two units are administratively managed by Doyne Hospital. There were 960 total admissions, with an average length of stay of 18.5 days.

Dual Diagnosis Inpatient Services

In FY92, MHC operated an average of 55 beds staffed to provide treatment focused on polydrug use by adults. Similar to the Substance Abuse Counseling services offered by MHC, these inpatient beds were originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, these beds are mainly used to serve persons with a primary disorder of substance abuse, due to the lack of services within the County for these individuals. These units served 617 individuals in FY92, with an average length of stay of 16.3 days. Similar to the Substance Abuse Counseling Services, it is strongly recommended that the resources for the dual diagnosis inpatient program be focused to specifically address the needs of people who have both mental illness and substance abuse issues. The Alcohol and Drug Abuse Bureau should be held responsible for developing services for persons whose primary issue is substance abuse.

Rehabilitation Inpatient Services

In FY92, MHC provided long-term, non-acute care to 406 adults with mental illness. These services were provided at two different locations, with a total bed capacity of 320. Rehabilitation Center-City Campus, with 128 beds, and Rehabilitation Center-Central, with 192 beds in FY92. Both are Medicaid-certified facilities licensed to operate as skilled nursing homes, and both serve geriatric and non-geriatric people with mental illness.

(During FY94, Rehabilitation Center-Central will be down-sized from 192 beds to 82 beds for people with mental illness. In addition, 140 people with a primary diagnosis of developmental disabilities who reside in Rehabilitation Center-South will be transferred to Rehabilitation Center-Central. The Central facility is now referred to as Rehabilitation Center-Main Campus, and is certified as a 222 bed Title XIX Nursing Facility with a distinct part-MR.) Rehabilitation Center-Central had 17 new admissions in FY92, with an average length of stay of 1,617 days. Rehabilitation Center-City Campus had 15 new admissions, with an average length of stay of 63.62 days (out of a possible 149).

Nursing Home Inpatient Services

In FY92, ASD contracted with a nursing home in the county to serve four residents with a mental illness. By FY99, these individuals will be over 65 years of age, and therefore will be able to access benefits outside of the mental health system to pay for their care.

Wisconsin State Institutes

This component reflects funding for several different situations related to ten individuals served by Wisconsin State Institutions in FY92. By Wisconsin State Law, the individual's county of residence is responsible for financial reimbursement for these services. First, funds were expended for forensic clients who were found not guilty by reason of insanity and had a mandatory release date, but were found in need of further treatment, and therefore, financial responsibility for treatment rests with the county. Second, resources were expended for patients transferred from Wisconsin Correctional Institute to Wisconsin Resource Center for treatment prior to their mandatory release date, and were then in the same situation as described above. Third, resources were expended for difficult patients who were transferred from MHC to a state institution for more secure, intensive treatment. Fourth, county resources were expended for state institution services provided to Milwaukee County residents who were detained there by another county until transfer to services within the county could be arranged. Based on expenses incurred in FY93, it is expected that additional resources will be needed to support this service in the future.

Private, General Hospital Inpatient Psychiatric Services

Twenty-nine private general hospitals in Milwaukee County also provided inpatient psychiatric services to 1,818 Medicaid-eligible persons (all ages) in FY92. By definition, these are individuals who have a disability, and are receiving psychiatric care. As such, it is safe to assume that most are individuals who might otherwise seek services from the public sector mental health system. Together, three of these hospitals (Sinai Samaritan, St Mary's Hill, and St. Michael's) served approximately 690 adults in their inpatient psychiatric programs in FY92 for whom Medicaid was billed $4,623,809 for their care.

In addition, thirty-six general hospitals also provided inpatient services for 3,682 persons (all ages) whose care was reimbursed by Medicare, also indicating that most are individuals who might otherwise seek services from the public sector mental health system. In FY92, Sinai Samaritan reported serving a total of 290 people (all ages) in their inpatient psychiatric program for whom Medicare was billed $2,692,416. Using a 15% adjustment factor for children and youth, the Medicare charges for adults served by this one hospital would be an estimated $2,288,500 in FY92.

As the Department of Human Services begins implementation of this Master Plan, it will be important to consider the role of general hospital (non-profit and profit) psychiatric services within the public sector system. Since many of these hospitals are already serving people who receive federal entitlements, and have therefore shown interest in addressing the needs of people who typically use public sector services, they may also be interested in service expansion in this area. It may be possible, for example, to contract with general hospitals for utilization of existing hospital beds for all or specialized inpatient services currently provided by the County Mental Health Complex, such a substance abuse or geropsychiatric services. Contracting with general hospitals has been used successfully in many areas throughout the country to increase patient access to high quality inpatient services and decrease overall system costs; many areas also have designated these hospitals as Designated Receiving Facilities, thereby giving them the authority to also treat persons under involuntary care. Several different approaches have been used to staff inpatient mental health services in general hospitals, including using the general hospital's own staff to provide all treatment and supervision, or using community mental health staff for supervision, for collaboration, or for direct care. Other locations have transitioned staff from the state or county-operated inpatient service to the local general hospital units.

For Milwaukee County, however, a careful cost-benefit analysis would need to be conducted to examine the feasibility of this option, since there are many variables that would need to be considered. For example, benefits include the fact that costs for general hospital bed utilization would only be tied to actual expenses associated with each hospitalization, and not to the indirect costs associated with sustaining beds within the free-standing, county-operated Mental Health Complex; services provided by general hospitals increase access to Medicaid reimbursement; and the stigma of mental illness is reduced by being served within the community hospital system and close to home rather than the County-run psychiatric facility located out of town. On the other hand, MHC is a primary employer within Milwaukee County, and the overall costs to the taxpayer, due to increased crosscharges and other aspects of overhead operations incurred by other county programs or possible county staff layoffs (see discussion in next section), of reducing or eliminating the Complex's role in inpatient service delivery may over-ride the benefits of contracting with general hospitals for these services.

ADMINISTRATIVE STRUCTURES AND SUPPORTS

REORGANIZATION OF THE DEPARTMENT OF HUMAN SERVICES

As noted in Chapter Two, in Milwaukee County there is no single point of authority with the resources or focus to pro-actively address the needs of the mental health system. In Milwaukee, the Department of Human Services has the ultimate authority for the mental health system. However, the Administrator of this Department has responsibility for all social services, with the exception of Corrections and Aging. Within the Department of Human Services, the Adult Services Division oversees the Mental Health Bureau (which has primary responsibility for all mental health services other than those delivered through the Mental Health Complex), Alcohol and Drug Abuse, Developmental Disabilities, Physical Disabilities, and Access and Brief Services. A separate division, the Mental Health Division, oversees all services provided by the Mental Health Complex. As such, there is no entity with a single focus on mental health which also has the responsibility to oversee ALL mental health services (those offered by the county-operated Mental Health Complex and those offered through provider agencies which contract with ASD). The result is a fragmented system, without the ability to develop comprehensive plans or policy, integrate/coordinate services, monitor service quality, coordinate with the State Bureau of Mental Health on state initiatives/policies, attend to Health Reform issues in the County, or target and be accountable for fiscal resources.

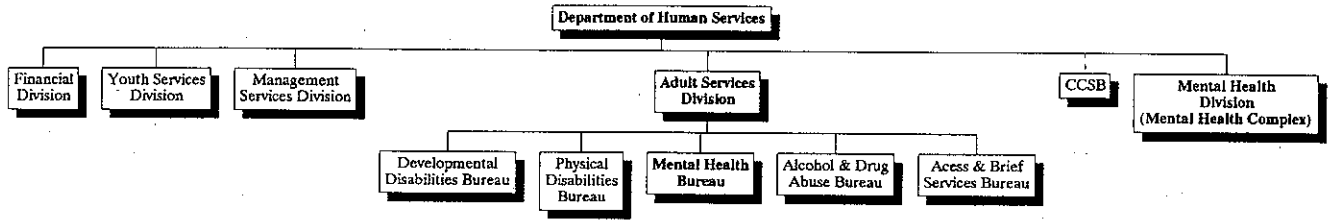
This lack of coordinated planning and the ability to develop a unified, proactive budget results in unfocused service development. There is little understanding between ASD and MHC and Milwaukee County Department on Aging about revenue sources and allocation, and the methodologies used for fiscal tracking differ significantly. As such, it is not possible, without a significant degree of staff time and effort, to develop a fiscal picture which reflects the total resources within the mental health system in Milwaukee County. In addition, since MHC is County-owned, there is concern by the County Board to develop new services that may need tax levy support. This situation results in limited funding for new or innovative programs or services, and a perpetuation of the reliance on inpatient services as the primary mode of care.

As such, it is strongly recommended that the structure of the Department of Human Services be reorganized to provide a mechanism to address these concerns. It is recommended that the structure be realigned to create a new Adult Mental Health Division within the Department of Human Services, with a designated Division Administrator and staff to adequately fulfill the responsibilities of planning, budgeting, contracting and monitoring service provision. The Division would have oversight over all adult mental services, in that it would consist of a County Services Bureau, comprised of the county-operated Mental Health Complex, and the Contract, Planning and Evaluation Bureau, which would contract with private provider agencies and with Milwaukee County Department on Aging (MCDA) for persons over the age of 60. Figures 11, 12a and 12b present this proposed organizational structure.

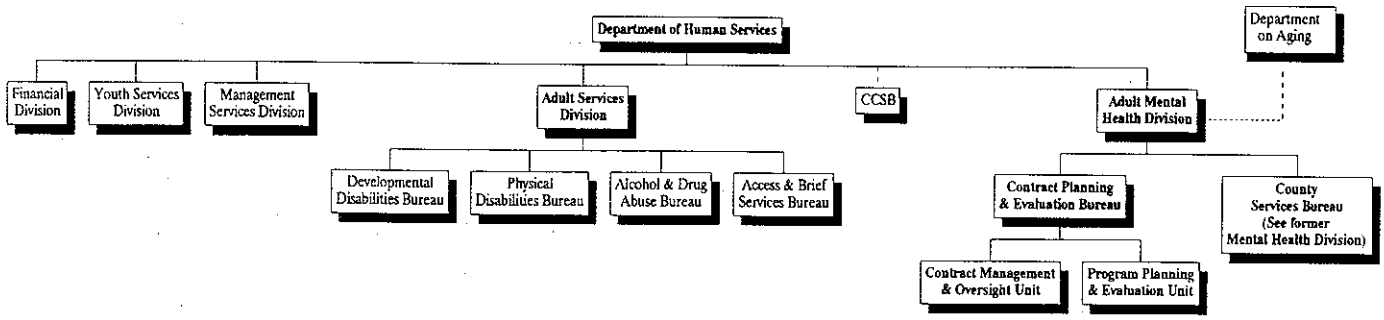
Figure 11

RECOMMENDED REORGANIZATION OF MILWAUKEE COUNTY DEPARTMENT OF HUMAN SERVICES

1993 Organizational Structure



Proposed Organizational Structure

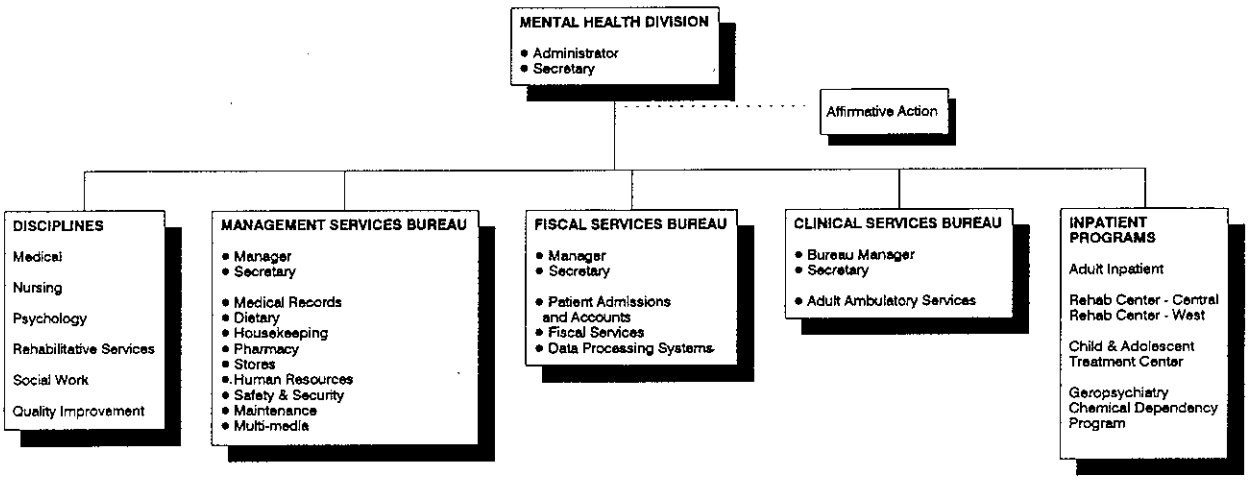


t:\ta\chart\org2a.cht

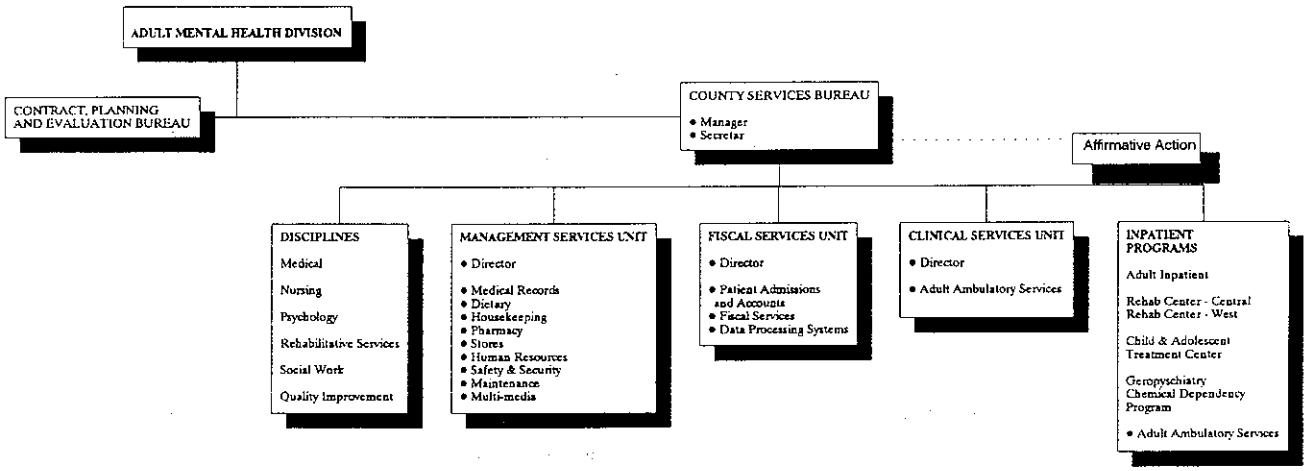
Figure 12a

RECOMMENDED REORGANIZATION OF MILWAUKEE COUNTY ADULT MENTAL HEALTH DIVISION

1993 ORGANIZATIONAL STRUCTURE MENTAL HEALTH DIVISION



PROPOSED ORGANIZATIONAL STRUCTURE ADULT MENTAL HEALTH DIVISION COUNTY SERVICES BUREAU (MCMHC)

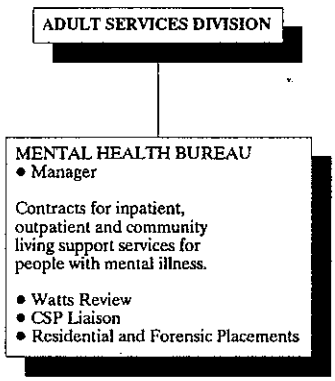


t:\ta\chart\orgstru3.cht

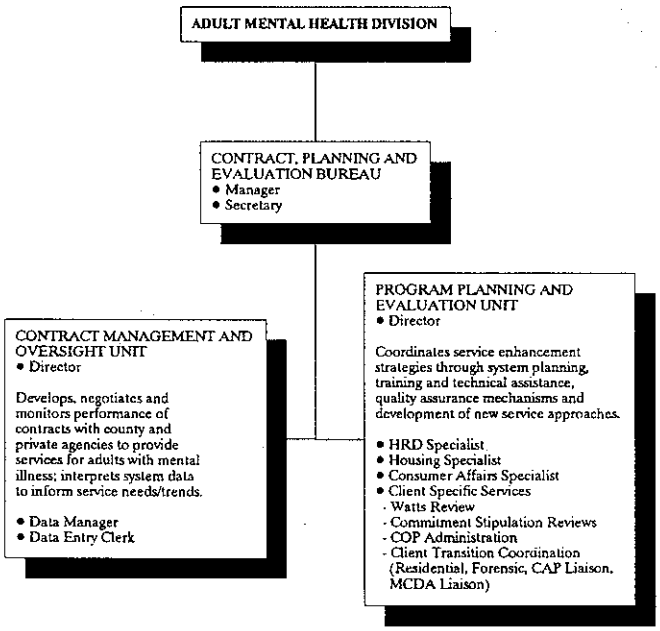
Figure 12b

RECOMMENDED REORGANIZATION OF MILWAUKEE COUNTY ADULT MENTAL HEALTH DIVISION

1993 ORGANIZATIONAL STRUCTURE ADULT SERVICES DIVISION MENTAL HEALTH BUREAU



PROPOSED ORGANIZATIONAL STRUCTURE ADULT MENTAL HEALTH DIVISION CONTRACT, PLANNING AND EVALUATION BUREAU



t:\ta\chart\evalbu2.cht

As can be seen in Figure 11, the Department of Human Services would still have five Divisions, but the Mental Health Division (which is totally comprised of the Milwaukee County Mental Health Complex) would become the County Services Bureau, and would function under the oversight of the proposed Mental Health Division (see Figure 12a). The Mental Health Bureau, which is one of five Bureaus within the Adult Services Division, would shift to become the Contract, Planning and Evaluation Bureau of the proposed Adult Mental Health Division, and would continue in its current role, as well as have new responsibilities, discussed below (see Figure 12b). As such, this re-organization does not create any new administrative structures, but instead realigns existing structures to provide one administrative organization with the authority and resources to implement a unified adult mental health service delivery system within Milwaukee County.

The Administrator of the Adult Mental Health Division would have overall responsibility for all public sector mental health services delivered for adults in Milwaukee County. As such, the Administrator would provide system leadership for implementing the vision and recommendations for the Master Plan, and would ensure that all policies, procedures, service planning, development and contracting, and resource allocation decisions are in congruence with the directions provided in the Plan. In addition, the Administrator would be the representative for the public sector adult mental health service system with the Department of Human Services Director, the County Executive and Board of Supervisors, the Wisconsin State Bureau of Mental Health, other relevant human service organizations within the county and state systems (e.g., Aging, Corrections, Youth, Homeless, Substance Abuse), Unions, provider organizations, advocates, and the community-at-large. For example, it would be the Division Administrator's responsibility to ensure that adequate planning is conducted to understand and provide services for the needs of individuals with a dual disorder of mental illness and substance abuse.

As indicated in Figure 12b, the Contract, Planning and Evaluation Bureau would have a Manager and two Units: the Contract Management and Oversight Unit and the Program Planning and Evaluation Unit. The Contract Management and Oversight Unit would have a director, who would develop, negotiate and monitor performance contracts entered into with both county (including MCMHC) and private agencies and the Milwaukee County Department on Aging (MCDA) to provide services for adults with mental illness (see discussion on page 111). This unit also would be responsible for overseeing the functioning of the management information system (MIS), discussed below, and for interpreting the MIS data to inform the system about service needs and trends (e.g., crisis service utilization rates for certain sub-populations of consumers; service utilization of specific ethnic groups). These activities would be performed by a Data Manager and Data Entry Clerk.

The Program Planning and Evaluation Unit would have a Director responsible for coordinating service enhancement strategies through system planning, training and technical assistance, quality assurance mechanisms, and the development of new service approaches. To facilitate system development, this Unit would have three staff with responsibility for specific aspects of the system: Human Resource Development (discussed below), Housing

Development (discussed above in the Services section), and Consumer Affairs (discussed below). The activities of this Unit would be provided for both county-operated and private agency services and staff. In addition, this unit would continue to conduct the client specific services it currently conducts, including Watts reviews, Commitment Stipulations reviews, and client transition coordination (coordinating transitions from residential or State Institute services, and coordinating with the Community Assessment Program and other assessment and triage components within the system, including the Department on Aging). A new function of this Unit would be administering COP, which currently is administered by the Mental Health Complex.

The County Services Bureau would be comprised of the existing Mental Health Complex, and could also incorporate any other county-operated services that might be developed by other organizations in the future. As shown in Figure 12a, the organizational structure of MHC would remain the same, except for title changes (i.e., the now Division Administrator would become the Bureau Manager, and so forth), although on-going internal management decisions are resulting in functional reorganizations which may ultimately cause structural organizational change (see discussion below). In addition, as downsizing of the inpatient services occurs, organizational re-structuring also may occur. Also, reductions in administrative staff may occur as a result of downsizing, although the extent of this would depend on whether MHC increases or decreases its provision of community-based services through contracts with the Adult Mental Health Division.

A primary effect of this realignment is that county-run services would be overseen by one entity (the Division of Adult Mental Health) which would make service development and funding decisions based on overall system needs, rather than based on two separate systems with competing financial interests, uncoordinated service development, incomparable financial and service utilization reporting mechanisms, and little accountability for resource utilization.

This proposed structure also would benefit the County Board of Supervisors, in that there would one single entity with a single focus on the public mental health system for adults, and across all services providers. As such, fiscal and programmatic requests from DHS for the mental health service system would be coordinated, and would be part of an overall plan which is agreed upon by the major constituencies within the system. This would free the County Board from the decisions it now must make without having the benefit of knowing the context of how the requests fit into the overall system. It also would hopefully result in more flexibility within the mental health system to respond to immediate needs.

The total new staffing costs for this reorganization would be $338,390 (see Table 6).

TABLE 6

COSTS ASSOCIATED WITH REORGANIZING DHS ADULT MENTAL HEALTH SERVICES DIVISION

STAFFING	SALARY + FRINGE	IS FTE COVERED BY EXISTING FTE	NEW COSTS
Adult Mental Health Division Administrator	$89,050	NO *	$89,050
Adult Mental Health Division Clerk Steno	$30,140	NO	$30,140
Contract, Planning, and Evaluation Bureau Manager	$61,650	YES	
Contract, Planning, and Evaluation Bureau Clerk Steno	$30,140	NO	$30,140
Contract Management and Oversight Unit Director	$56,170	NO	$56,170
Contract Management and Oversight Unit Data Manager	$41,100	YES**	
Contract Management and Oversight Unit Data Entry Clerk	$30,140	NO	$30,140
Program, Planning, and Evaluation Unit Director	$56,170	NO	$56,170
Program, Planning, and Evaluation Unit HRD Specialist	$46,580	NO	$46,580
Program, Planning, and Evaluation Unit Housing Specialist	$46,580	YES	
Program, Planning, and Evaluation Unit Consumer Affairs Specialist	$41,100	YES**	
Program, Planning, and Evaluation Client Specific Services:			
WATTS Reviews (2.0 FTE)	$82,200	YES	
Commitment Stipulations Reviews	$41,100	YES	
COP Administration and Access (4.0 FTEs)	$164,400	YES***	
Client Transition Coordination (CCRC, Forensic, CAP Liaison)	$41,100	YES	
TOTAL NEW STAFF COSTS			$338,390

OTHER NEW COSTS	ANNUAL COST		
Consumer Organizing, Development, TA Budget	$48,900	NO	$48,900
Staff Training, Development Budget	$250,000	NO	$250,000
Service Evaluation Activities	$100,000	NO	$100,000
TOTAL OTHER NEW COSTS			$398,900

TOTAL NEW COSTS FOR DHS REORGANIZATION (ON-GOING)	$737,290

MANAGEMENT INFORMATION SYSTEM COSTS	ANNUAL COST		
Implementation (Hardware, software, networking)	$2,208,000	NO	$2,208,000
On-going Maintenance (.5 FTE/agency data entry, upgrades, etc)	$513,992	NO	$513,992

* Assumes current MHC Administration would maintian current slary levels and positions

** Assumes reassigning existing positions within the current Adult Mental Health Bureau

*** Exisitng COP Services at MHC would transfer to DHS

CHILDREN AND YOUTH SERVICES

MHC provides almost all public sector mental health services for Children and Youth in Milwaukee County. There are at least two options for addressing this issue in the proposed DHS reorganization. First, the Youth Services Division could contract with MHC for these mental health services, using a similar procedure to that proposed within the Adult Mental Health Services Division. An alternative approach would be to give authority for all mental health services, with the exception of those addressed by the Department on Aging, to the new organizational entity, thereby creating a Mental Health Division with oversight for all contracted and county-run mental health services for persons under the age of 60. Since this planning process did not include services for children and youth, the best approach to deal with this issue is unclear. However, the *proposed DHS reorganization for adult services should not be delayed* due to this issue, in that temporary agreements or arrangements can be made while this issue is resolved.

It is strongly suggested that a similar planning effort begin immediately to examine the public sector mental health system for children and youth in Milwaukee County. Although they often function as two separate systems, they interface very directly in a number of ways. One obvious interface is the service provision to both populations by MHC. In addition, many of the individuals who receive mental health services as children and youth will transition to the adult mental health service system to continue receiving services; therefore, these two systems often serve the same people at different points in their life. One implication of this is that the values on which service are based must be consistent for the two systems, and services should be designed which reflect these shared values and service approaches.

In addition, a more proactive, successful intervention at an early age should result in less need for intensive adult services later in life, which would have both humanitarian and financial rewards for the citizens of Milwaukee County.

MHC MANAGEMENT STRUCTURE

The matrix system of management at MHC has become a focus of concern for a number of reasons: there is little clarity about the respective roles and responsibilities of Program Administrators vs. Discipline Administrators; staff are confused about who to report to; daily staffing assignments are at the discretion of Discipline Administrators, which can result in inadequate program staffing and individual staff frustration; and program budgets are not controlled by program managers. The MHC Administrator has addressed this issue by developing a clear management structure that fosters a focus on quality of services to patients, rather than on job descriptions and authority, and includes the development of clear roles and responsibilities for Program Administrators and for Discipline Administrators. It gives Discipline Administrators the responsibility for the performance of their discipline, as it relates to patient outcomes, including quality assurance activities,

privileging, and clinical supervision of staff, and gives Program Administrators the responsibility and accountability for programmatic outcomes and resource management.

CONSUMER OUTCOMES

Traditionally, the focus within mental health systems has been to maintain existing programs, and to develop models of service delivery based on the requirements of funding sources in order to continue revenue receipt. Recent national trends, however, focus on providing high quality care and effective resource utilization, as is evidenced by the emphasis on managed care in the health delivery system. All the recommendations in this Master Plan move the Milwaukee County public sector mental health system in this direction.

At the heart of this plan is the assumption that all services should focus on achieving positive outcomes for the people they serve, and that funding sources and strategies are mechanisms for achieving these outcomes. Survival of programs or provider agencies should be dependent on the quality of the services they provide, measured in terms of consumer outcomes and satisfaction. Specific consumer outcome indicators will need to be developed for each individual service component, and these outcomes should reflect the changes in individuals' lives that the program is meant to accomplish. Such key consumer outcomes include increases in rates of consumer employment, at which consumers receive income support and entitlements, at which consumers achieve desired and decent housing, and at which consumers are actively engaged in natural support networks; and decreases in symptomatology, crisis service and hospital utilization rates, numbers of days spent incarcerated and/or homeless, and rate of substance abuse. These outcomes also should be aggregated across all service components by the Adult Mental Health Service Division to assess system effectiveness and identify gaps.

Satisfaction measures should focus on consumer and family opinions of service quality, including indicators of service accessibility and responsiveness; flexibility based on individual needs; respectfulness; cultural and ethnic sensitivity and relevance; emphasis on consumer choice and involvement; and other values which are contained in the Guiding Principles. There are a variety of methods for collecting this information, including surveys, focus groups, attending family and consumer meetings, and developing consumer satisfaction teams which visit programs and speak directly with consumers and family members, and see the services first-hand.

The Adult Mental Health Division must begin a process to identify specific outcomes for each service component and to develop methods for assessing performance on these outcomes, as well as methods for assessing service satisfaction. Without such information, it is impossible to monitor whether the system is using its resources to effectively meet the needs of its service recipients. Other areas in the country have used working groups of consumers, family members, and staff of the particular service component to develop outcome and satisfaction indicators and methods for measurement, with the understanding

that the methods and indicators must be somewhat uniform across all services to minimize disruption of service delivery to respond to multiple evaluation requirements. In addition, efforts must be made to work with the State Bureau of Community Mental Health to reduce duplicative paperwork to meet state evaluation requirements.

MANAGEMENT INFORMATION SYSTEM

A good management information system is a vital component of any successful service system, in terms of quality, cost effectiveness, and client satisfaction. Such a system does not exist in Milwaukee County. For example, obtaining and summarizing the revenue information for this planning project was challenging for the project consultants and for the MHC and ASD staff who provided it to the consultants. There also is minimal ability to track service use of individual clients, to identify people who use/need intensive services, or to identify unduplicated count of people receiving services in a given timeframe. In addition, the existing data system does not provide adequate information about patients, including previous hospitalizations, medications, community service use, and so forth. As a result, there is little ability to know important clinical information (e.g., case manager, relevant previous history, current medications, allergic reactions) when someone accesses a new service component or is in crisis.

To address this vital need for a mechanism to monitor service utilization and to provide necessary clinical information about individuals receiving service, the Adult Mental Health Division needs to create a standardized data and management information system, with individual, unique client identifiers, that can be implemented at contract agencies and at MHC. This system should be developed to maintain individual confidentiality, as well as have the ability to evaluate program outcomes. It also should be used to provide timely information to the provider system about the performance and service use and needs within the public sector mental health system in the County. Such Management Information Systems recently have been implemented within other areas of the Milwaukee community, including the community general hospitals, municipal and circuit courts, the Milwaukee Police Department and the Milwaukee Health Department.

It is estimated that the one-time costs of implementing such a MIS would be approximately $2,208,000. These costs would include approximately $1,600,000 for the mainframe, system consultation and installation, other hardware and software needs, located at one main site; approximately $100,000 per site for stand-alone systems that would be networked with the mainframe but also have a 16-user site license to allow multiple access stations, projected to be needed at four of the largest provider agencies; and approximately $4,500 per site for twenty-four agencies to be networked with the mainframe through a personal computer and modem.

In addition to the one time costs, approximately $514,000 is needed for on-going maintenance of the MIS. This estimate includes costs for .5 FTE data entry position at each of the networked agencies, costs for software and hardware upgrades, and so forth. The Data Manager of the Contract Management and Oversight Bureau Resources would oversee the MIS, and provide consultation to networked agencies. Resources to provide training for using the MIS would be part of the HRD training budget discussed below.

PERFORMANCE CONTRACTING

It is recommended that the Adult Mental Health Division use a Request for Proposal (RFP) process to develop new community-based services and to continue to fund those community-based services that exist, including those provided by MHC and other county-operated agencies. This RFP process is, in essence, a competitive bidding process which dictates that providers detail the services they are willing to provide, the costs associated with providing those services, and the outcomes to be achieved by their service recipients. As such, it encourages provider organizations to develop clear directives for their services, and it allows the funding organization to contract with provider agencies that are best equipped to provide high quality and cost efficient services. As such, it is vital that proposals first be reviewed based on established technical specifications to meet the desired service quality and characteristics (e.g., mode and location of service delivery, staffing ratios, intended consumer outcomes, involvement of consumers and family members in design and implementation of service, cultural and ethnic competence, adequacy of staff salaries and benefits, and so forth), and then those that meet the technical specifications should be reviewed according to proposed cost. Without using technical specifications as the preliminary review criteria, RFP processes are subject to relying on a "low cost bidder" approach which may result in service development that is also of low quality and/or has inadequate supports for staff to be able to achieve positive outcomes.

All services, including inpatient and community-based services, should be provided through a performance contracting mechanism which would hold providers accountable for outcomes and resource allocation. This would enable comparable service quality expectations, fiscal and service utilization data, and outcomes for the individuals being served. The annual review of these contracts should be based on the agency's performance regarding expected outcomes for consumers, as well as adherence to standards developed to reflect the Guiding Principles for the service delivery system.

CAPITATION INITIATIVES

The combination of having clear target population definitions, using a RFP process for all services, and performance contracting with all providers could allow the Division to develop a capitation initiative for people with the most severe needs. In capitation systems, all funds are consolidated in one pool and a predetermined amount is allocated to providers who

contract to meet all the needs and achieve desired outcomes for specific groups of individuals (i.e., long stay inpatient residents). In capitated systems, the provider is responsible for effective utilization of the allocated resources across all individuals for all services needed by each person (including community and inpatient services), thus encouraging more proactive service provision to prevent the need for more intensive, costly reactive services. In essence, it is a managed care approach to serving people with the most intensive needs, but one that focuses on consumer outcomes rather than on funding source requirements. Performance contracts, MIS data, and service evaluation activities are used to assure that individual quality of care is enhanced rather than compromised through the capitation process.

Capitation initiatives also encourage high quality inpatient services, in that there is a strong incentive for good communication regarding admission, treatment and discharge planning between the community and inpatient staff assisting the individual consumer. There also is strong incentive for inpatient programs to refine their services based on the specific needs of the people who require specialized clinical services or treatment, and thus, reinforces the notion that inpatient services must also be held accountable for consumer outcomes, rather than be seen as the "holding tank" for people no one wants, or has the resources, to serve.

MASTER PLAN ADVISORY COMMITTEE

It is strongly recommended that DHS maintain the Mental Health Master Plan Advisory Committee beyond the completion of the planning project to oversee implementation of the Plan, advise the Adult Mental Health Division, and keep a proactive focus on the system's vision and mission. This committee could continue as a free-standing group, or could become a committee of the existing Combined Community Services Board, with the charge of being the entity which is focused specifically on mental health concerns. Such Advisory Committees have been used very successfully in other locations to assist implementation of system change initiatives and Master Plans (e.g., Tennessee, Vermont).

The composition of the committee should be examined to be sure that all relevant constituencies are included, and that committee members will make a commitment to, and have enthusiasm and energy for, active participation on the committee. Since this Plan recommends that all boards and advisory committees have a goal of 50% consumer involvement (see section on Consumer Involvement), the Master Plan Implementation Committee should be a model for this principle. In addition, mechanisms should be established to support the initiation and participation of all new committee members, in that they will be joining a previously-existing group with a strong understanding of the content and purpose of the Master plan, and of the role of the Advisory Committee in the implementation of the Plan. This is especially true for consumers, who may not have had the opportunity to participate on such committees and therefor may not know how to be an active member, and for whom it may be very difficult to serve on a group with professionals

with whom they have had clinical experiences. To address this concern, a buddy system should be initiated, pairing an existing member with a new member.

A committee chairperson should be appointed to organize meetings and be the liaison between the committee and the Adult Mental Health Division. It is important that County Supervisors continue to have active involvement on the committee, to serve as the intermediaries between the actions and needs of the mental health system and the actions and needs of the County governance system.

COUNTY BOARD OF SUPERVISORS

Mental health is a very complex field that intersects with almost every other human service system. Due to this complexity, it is often difficult to fully understand the ramifications of single decisions on the mental health system as a whole, or on other systems with which it intersects. In addition, the implementation of this Master Plan will demand a great deal of time and attention by the County Board of Supervisors over the next few years, as will the advent of National Health Care Reform. In order to better serve the demands on, and needs of, the County Board of Supervisors, it is recommended that a free-standing Mental Health Committee be created within the County Board to focus specifically on mental health issues. This entity would interface between the full County Board of Supervisors and the Department of Human Services Director, the Adult Mental Health Division, and other Divisions or Bureaus which serve people with mental disorders.

HUMAN RESOURCE DEVELOPMENT

Note: Many of the recommendations contained in this section were developed by a workgroup or individual members of the Mental Health Plan Advisory Committee, and thus, directly reflect the values and desires of relevant constituencies in Milwaukee County.

Staff are the "bricks and mortar" of high quality, responsive mental health service delivery systems. Unfortunately, most mental health systems, including Milwaukee County, focus little attention or resources on maintaining or enhancing this vital element of service effectiveness. For example, the annual staff development budget of the Mental Health Complex is $14,000 for its staff, and the Adult Services Division has no dollars directly allocated for this purpose. As such, it is extremely difficult to recruit and retain a workforce that is adequately skilled, culturally relevant, and dedicated to helping people with mental illness achieve their desired outcomes.

Implementation of this Master Plan cannot be successful without a strong focus on the human resource development needs within the system. New staff will need to be recruited and trained (Recruitment and Pre-service Training) and existing staff will need to learn new skills and be given opportunity for advancement (In-service Training and Redeployment Opportunities). As can be seen in Figure 12b and Table 6, it is proposed that the proposed Division of Adult Mental Health would have 1.0 FTE staff to focus on human resource development needs, with an annualized budget for staff training and development of $250,000.

Implementation of a comprehensive, responsive mental health system, such as the one described in this Master Plan, also requires flexibility regarding staff salaries (even within the same job titles), benefits, incentives, job descriptions, and work regulations to utilize and reward staff as needed, and in a manner that motivates and rewards positive work performance. Many of the recommendations and strategies that follow are based on the assumption that the leaders within the Milwaukee County public mental health system will work collaboratively to develop guidelines, agreements, and practices to allow this Master Plan to be implemented, both for the benefit of the staff as well as the service recipients.

Recruitment

One of the major problems within the mental health field is the recruitment of well-trained and motivated staff who are committed to working with people with serious mental illness as a life-long career. Part of the difficulty lies in the stigma associated with mental illness. Developing and promoting a clear vision and mission for the service delivery system that emphasizes positive consumer outcomes, such as that contained in this Master Plan, should help reduce the negative expectations often associated with this field. In addition, efforts must be taken to address issues of salary equity, training, and other incentives which effect the desirability of this field for a life-long career.

Adequate Salaries and Benefits

The Department of Human Services should develop a mechanism to routinely collect information on mental health staff salaries and benefits at all staff levels, and compare these to salaries and benefits of staff in other human service systems, both within Milwaukee County, and within other similar and competitive locations within the region (e.g., Columbus, Cincinnati, Indianapolis). Consideration of differences in staff expectations (e.g. caseload sizes, needs of individuals served) within the different service agencies must be considered in this process, however. Creating this database would enable establishment of ideal salary/benefit targets to be considered in annual budget development and negotiations.

Staff Incentives

There are several strategies which, if incorporated into the Milwaukee County system, would increase the likelihood that new people would want to work within the mental health system, that existing staff remain within the workforce, and that would facilitate professional growth. These include staff recognition strategies within individual agencies and within the county system as a whole; staff involvement in agency decision-making and county-wide system planning and service development; and opportunities to attend conferences, take sabbaticals, and participate in professional exchanges between agencies and higher education institutions.

Staff recognition strategies can be classified in two categories: monetary and non-monetary recognition. Often in mental health systems, non-monetary recognition includes designation as the "worker of the month/year," providing gifts to employees in recognition of "years of service" to the agency, and identifying those workers who demonstrate outstanding abilities to serve persons most in need and "rewarding" those workers by assigning them additional challenging cases. Although these are valuable strategies, one of the highest aspects of employee satisfaction within mental health is being empowered to be involved in all aspects of service delivery, including policy development, program planning, and new staff recruitment, hiring and training. In essence, staff want to have recognized their expertise about service functioning and their awareness of the changes needed to facilitate achieving the desired outcomes for consumers. In the same way, the system needs to rely on this expertise of front-line staff to identify needed service and overall system changes. One strategy to achieve this goal is to include direct line staff in any policy or program development activities conducted at the agency or county-wide level. Another very effective strategy is to convene focus groups of staff to identify issues which need to be addressed within a specific service area and to brainstorm possible solutions to address the issues that are identified. By directly involving these staff, service systems empower their staff while simultaneously improving their services.

The existing staff classification system of job categories with "steps" in salary increments based primarily on years of service often makes it difficult to financially award workers for motivation, expertise and commitment, regardless of years of service. This can be changed if the Union, Management and the Department of Human Resources work together to develop measurable indicators that will enable the award of salary increments for excellent performance, in addition to rewards for longevity of service. These rewards could be given to reward team performance as well as individual performance, thereby reinforcing the principle of working together to achieve positive outcomes for consumers.

Additional strategies to recruit and retain motivated, qualified workers include: 1) opportunities for sabbaticals and respite; 2) rotation of workers into less intensive positions at regular intervals for a prescribed amount of time; and 3) adaptation of work schedules, allowing for flexible hours within a given day or a stratified schedule within the work week or month with a number of days worked consecutively followed by an extended number of off days. For example, the federation of Nurses and Health Professionals' contract allows flexible schedules, with agency management approval, and this option should be utilized as

much as possible. Many other creative strategies can be formulated by the workers themselves to meet this important need.

Pre-service Training

Typically, higher education programs have not adequately prepared professionals for working with people with serious mental illness. In addition, many direct line staff within mental health enter the workforce without specific training or knowledge about mental illness. In Milwaukee County, there are multiple institutions of higher education with a wealth of faculty and students being educated to work within the public mental health field. The Adult Mental Health Division should support educational and research programs, and utilize the resources of the Medical College of Wisconsin, the University of Wisconsin Medical School, the University of Wisconsin Milwaukee, Marquette University, Alverno University, Mount Mary, and the County Nursing Program to support the development and implementation of the proposed service system. Support of academic, training and research programs will enhance the Milwaukee County mental health system in three primary ways: increasing the workforce capacity, increasing the competence of the workforce, and increasing opportunities for new service development and enhancement.

Workforce Capacity: Many of the professional workforce come from academic programs within Milwaukee County. For example, much of the psychiatric care provided for people who use public sector mental health services is provided by psychiatry residents. As such, these residents provide a capacity which, if given opportunities for appropriate education and training, could increase the amount of psychiatric care available to patients in expanded community services. In all academic disciplines, properly designed educational programs train future professionals to work effectively in community mental health systems and play a role in producing successive generations of providers who will work within the system. In addition, programs should be initiated for high school and technical school students who may develop longer term interests in the field.

One of the best mechanisms for recruitment and retention of well-trained professionals for future jobs in the public sector is the provision of training opportunities in public mental health settings, including inpatient services, CSPs and other non-office based services, crisis intervention services, and specialized services, such as geropsychiatry, substance abuse, homelessness, forensic, and so forth. This also increases job satisfaction of program staff, in that it creates a stimulating academic environment within the public sector services and programs. These training opportunities can be developed through several mechanisms, including contractual agreements, in which the service agency contracts with the academic department to provide specific training, research, and specialized services; a close integration model, in which, for example, the department chairperson or faculty provide clinical services in which the students are part of the service program; and, a clinical rotation model, in which the students work within the program and are supervised by both their service and their academic supervisors. All three models can be used effectively within Milwaukee County. In fact, in FY92, 17.14 FTE positions for adult services were staffed by

psychiatric residents (8.14 FTEs), clinical psychology trainees (7.0 FTEs) and summer interns (2.0 FTEs), which represented an investment of $782,000 in salary and FICA. These valuable and cost effective training positions should be protected, and potentially enhanced, within any shifts in service delivery.

Workforce Competence: Good academic programs which emphasize state-of-the-art approaches for assisting people with mental illness can drastically affect the ultimate competence of the workforce. As such, it is imperative that the primary educational settings for the core professional disciplines of psychiatry, psychology, social work, nursing, and occupational therapy be provided with resources to provide students with the most current information and good training opportunities within the public sector mental health system.

In addition, it is important to provide rewards for professionalism, such as providing stipends for taking higher education, continuing education, or certification courses. For example, in FY92 the Federation of Nurses and Health Professionals (FNHP) had a pool of $1500 per person for credit classes, and approximately $250 per person per year for continuing education and certification courses. FNHP also has initiated a program, beginning in FY95, to provide an annual bonus of $500 for every nurse who meets certification requirements, and this amount will increase to $600 in FY96.

Research: Research grants, which are acquired by, or in collaboration with, academic institutions, enhance the quality of service and competence and motivation of the workforce, and raise the national reputation of programs and the overall service system. Existing examples of this would be the Medical College of Wisconsin grants on psychosocial aspects of HIV infection, and the University of Wisconsin grant on outcome assessment for treatment of alcohol dependence. Also, academic programs have personnel and expertise to conduct program evaluation research which is necessary for continuous improvement of the system.

In-service Training

All staff throughout the system need ongoing training opportunities to learn how to do their jobs better. Important training topics include understanding mental illness symptoms and psychotropic medications and their side effects; assessment, diagnosis, and effective treatment/service planning; substance abuse and homeless issues; outreach case management; crisis prevention, intervention, and resolution services; psychosocial and vocational services; and the specific needs of elders with a diagnosis of mental illness.

There are a variety of efficient strategies for providing needed training opportunities. For example, the training of trainers model involves providing in-depth training, as well as hands-on skills teaching and consultation, to several staff within the county or one staff from each provider agency. Either staff can be supported to attend external conferences/trainings or external trainers can provide the training within the County. The staff who participate are then expected to provide training for other agency staff. An example of this model are

Staff Development Nurses at MHC and Doyne Hospital who are responsible for orientation and on-going training of all nursing personnel.

Another effective method is to have county-wide conferences for direct and supervisory staff which focus on the systems change initiative and workshops on how to provide specific services. These conferences often give staff opportunity to take ownership in, rather than focusing on their fear of, the systems change. The considerable expertise which already exists within Milwaukee County model programs should be used in these training events.

In addition, inpatient/community staff cross-training is an effective method for assisting all mental health staff to learn about components of the service system with which they are unfamiliar, and simultaneously fosters the development of a seamless system for service users. Joint training opportunities need to be provided for inpatient and community staff about comprehensive service system approaches, descriptions of existing services and programs and new services to be developed, how to work together as a team to develop quality treatment and discharge plans, and so forth. Enabling inpatient staff to spend a day in outreach community-based services (e.g., with CSP teams), and developing a staff exchange program for inpatient and community staff also would facilitate this goal.

As in most systems, there still are many individuals involved in the service delivery system who hold overly protective and patronizing values about people with psychiatric disabilities. Such attitudes can have very negative effects on system reform. As an example, involving consumers in meaningful roles in mental health agencies may meet major resistance from staff, even in the most progressive agencies. These attitudes need to be recognized and constantly challenged. The involvement of consumers in substantial numbers in all planning, quality assurance, and training activities is very effective in helping to shift the attitudes of non-consumer staff, as is promoting employment of throughout the system, including in senior positions. These activities also provide a model for consumers within the system to understand that they can have valued roles in the system.

Staff throughout the system also will need to be trained in the usefulness and data collection methods for the new MIS categories. Because the MIS will include a focus on outcomes, this training will provide an unique opportunity to convey to all staff the emphasis on helping individuals to achieve positive life outcomes. It is well known that people define the purpose of their job by the types of data they are asked to collect; as such, asking staff to collect information on client outcomes rather than units of service should prove to be a very effective method of staff training in and of itself. Collecting information on "client outcomes rather than units of service" must become an absolute priority to ensure that the consumer is receiving the best possible care. Otherwise, staff performance in serving individuals is incorrectly measured by successful, accurate and timely completion of forms rather than the quality of collateral and face-to-face interactions with the consumer, family members, neighbors, and other service providers. It is the quality of these interactions which is the real "data." "Data collection's" primary purpose is to enhance services to the client; information needed for administrative purposes should be kept to a minimum. As such, DHS must take advantage of this opportunity to delete any paperwork requirements

that are no longer absolutely necessary for successful service delivery. Creative strategies must be developed to coordinate, streamline and simplify paperwork requirements with direct input and feedback from staff who complete these forms on a daily basis.

Another training need is for non-mental health staff. For example, law enforcement and correctional systems interface directly with the Milwaukee County mental health system; however, personnel within these systems lack knowledge or skills about mental illness and effective treatment approaches or available services. As such, initial presentations need to be provided for key personnel within these systems about the future directions of the mental health system within Milwaukee County, and then follow-up training need to be available on specific topics that directly affect successful intervention and service delivery (i.e., basic information about mental illness crisis intervention, de-escalation of crises, and available community services and resources).

Regardless of the training content, primary consumers and family members should have a prominent role in designing and providing all training events. In addition, training need to address the needs of both introductory-level and advanced staff, who work both in direct service and management roles. Training also should be linked, whenever possible, to higher education institutions and build in opportunities for academic credit, continuing education units, and certificates.

Redeployment

Throughout the country, inpatient down-sizing has occurred with very little unemployment of inpatient staff through use of natural attrition, early retirement incentives or employment assistance. In terms of the latter, MCMHC inpatient staff will need opportunities and training to become community program staff, if they so desire, and mechanisms will need to be developed to review their credentials and experience to assist this process.

There also may be staff employed in community agencies who do not feel comfortable with the new emphasis on an outreach rather than office-based service delivery model. It is important to recognize and support these individuals in their decision, in that quality services can only be delivered by staff who embrace the Master Plan service philosophy. As such, these agencies will need to assist these individuals to locate other jobs within or outside of the public mental health system which meet their needs and which correspond to their skills.

Because of the shift in emphasis from office-based to outreach services, job descriptions and qualifications may need to be re-written to emphasize new tasks and skills, and experience and educational requirements for staff may change. For example, staff may be hired based more on their ability to relate with consumers than on educational experience, and non-mental health trained people may be hired as housing coordinators, vocational counselors, or respite workers. In addition, to hire consumer staff, experience as a mental health consumer may need to be made equivalent to having an educational degree.

ETHNIC AND CULTURAL DIVERSITY AND COMPETENCE

Note: The recommendations contained in this section were primarily developed by a workgroup of the Mental Health Plan Advisory Committee, and thus, directly reflect the values and desires of relevant constituencies in Milwaukee County.

Cultural competence is defined as the ability to address the individual needs of a person across a wide spectrum of diversity issues (e.g., ethnicity, race, age, gender, sexual orientation, physical and mental disabilities), while ethnic competence refers to the ability of the service system to provide services and staff that understand the norms and values which exists for people from specific ethnic backgrounds.

The mental health service system in Milwaukee must attend to issues of both cultural and ethnic competence, in that this area has been neglected in the past years. As a result, there are few provider agencies which have services targeted specifically to people of color or from various ethnic or cultural backgrounds. In addition, recruitment and employment of staff who are of color must be a priority, since they are very under-represented within the workforce. This is especially true at the management level, where effective policy and service planning requires input from individuals with this perspective.

This issue was highlighted in the 1993 Affirmative Action Plan of the Milwaukee County Mental Health Complex. As noted in this Affirmative Action Plan, MHC administration is aware of the need to enhance efforts to meet the "goals of recruitment and employment of qualified Black and Latino Psychiatrists, Psychologists, Social Workers, and other Administrators and Professionals of Color." (page 17). Although 42% of persons hired by MHC in 1992 were minorities, most were in lower level positions, although 2 of 7 new psychiatrists were Asian males. As such, there still is under-representation of minorities in Official and Administrative Positions (12.5%) and Professionals (15.5%), while a high percentage of Paraprofessionals (75%) and Service/Maintenance staff (65%) are minorities. The MHC Affirmative Action Plan mentions several different strategies undertaken by MHC to address this issue, including attendance at national professional meetings, out-of-state advertising, and promotions. Other efforts are targeted to influencing the future workforce, such as a successful program within Rehabilitation Services which provides intern stipends for students of color; efforts to motivate high school students (including minority students) to consider careers in the mental health field; and providing inservice trainings for existing staff on culturally relevant and culturally specific topics. Each of these are valuable strategies, but a VERY PROACTIVE approach must be taken to ensure successful recruitment and hiring of minority mental health professionals. In addition, the implementation of the Human Resource Development strategies discussed above must occur in order to successfully recruit and retain minority professionals within the mental health system in Milwaukee County.

The Adult Mental Health Division also needs to periodically review service patterns for people of color, including the differential nature of diagnosis, access, discharge planning and follow-up, quality of outcomes, patterns of mental health service utilization, service representation for persons of color, and utilization of the criminal justice system.

Figure 13 presents information about FY92 mental health service utilization by different ethnic groups as compared to the ethnic representation within the total population of Milwaukee County. This Figure shows that MHC and ASD Mental Health provided services to a smaller percentage of Whites, American Indians, and Asian Pacific Islanders than there are in the general population of the County, and to a higher percentage of African Americans. For people of Hispanic origin, a smaller percentage then in the general population were served in the MHC Adult Acute Inpatient programs and more than the general population were served by ASD Mental Health contract agencies.

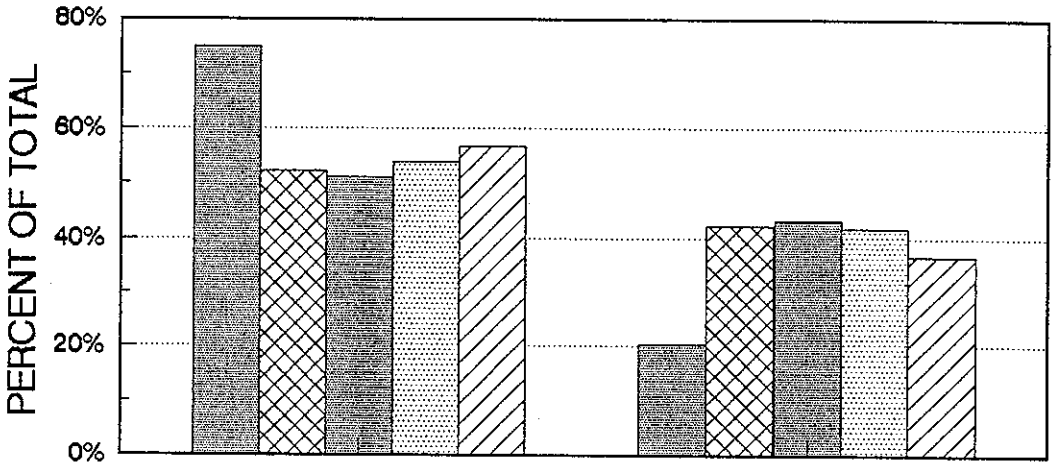
During the course of this planning process, many informants suggested that people of color are not appropriately represented as service recipients due to lack of culturally relevant programming. According to this data, this would be true for American Indians, Asian Pacific Islanders and for Whites. As such, it is hard to interpret this data according to discrimination patterns. For example, these data would suggest that there might not be culturally relevant services for American Indians and Asian Pacific Islanders, and thus, they are not receiving the services they need. This also could be argued is the case for Whites. Interestingly, when examining the ASD data in more detail, Whites account for substantially more of the CBRF and Work program clients, and thus other ethnic groups are not well represented within these services. On the other hand, *more* African Americans receive services than would be expected within the general population when looking at MHC admissions, crisis services, acute inpatient, and overall ASD mental health services (with the exception of CBRF and work programs mentioned above). It is difficult to interpret this data without more in-depth study; as such, the Adult Mental Health Division must make a concentrated effort to study these issues in more detail and develop services and staff supports to develop more ethnic and culturally responsive services.

These issues are highlighted in the Mission statement developed for Milwaukee County Mental Heath System (see Chapter 3), which states the need for services which are culturally competent, service providers that represent various cultural groups, and ongoing training within the workforce on cultural diversity issues. In order to develop proactive strategies to address these needs, the mental health service delivery system should:

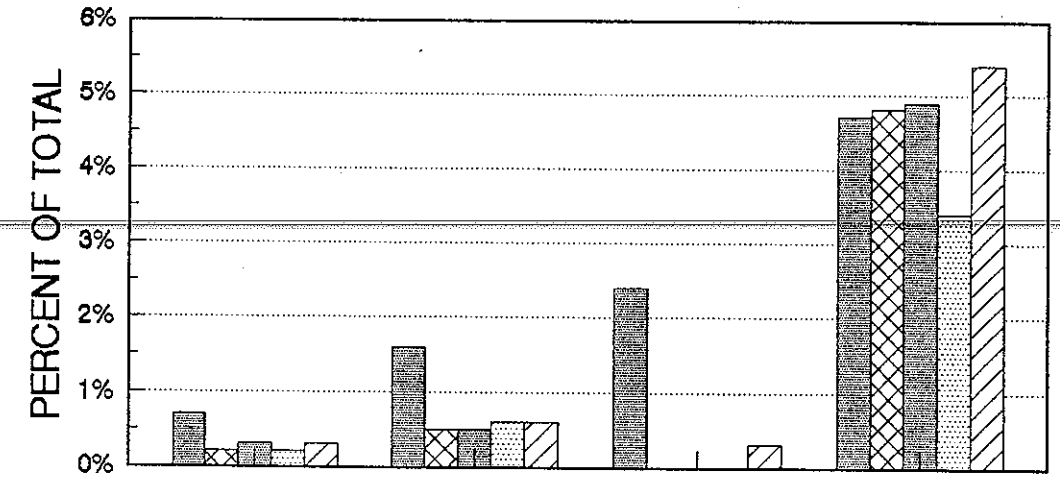
- Encourage and promote agency-level cultural and human competency in all policy development activities.

- Develop and implement policies that ensure equity in service funding, access, and quality of care for persons of color, persons with differing disabilities, and persons with a same sexual orientation.

FIGURE 13
SERVICES UTILIZATION BY ETHNIC GROUP
(GROUPS SPLIT DUE TO GRAPH SCALING)



	WHITE	AFRICAN AMERICAN
TOT POPULATION	74.9%	20.3%
TOT MHC ADM	52.2%	42.3%
PCS CLIENTS	51.0%	43.3%
ADULT ACUTE INPT	53.6%	41.9%
ASD MH BUREAU	56.8%	36.7%



	NATIVE AMERICAN	ASIAN/PACIFIC	OTHER	HISPANIC
TOT POPULATION	0.7%	1.6%	2.4%	4.7% **2
TOT MHC ADM	0.2%	0.5%	**1	4.6%
PCS CLIENTS	0.3%	0.5%	**1	4.9%
ADULT ACUTE INPT	0.2%	0.6%	**1	3.4%
ASD MH BUREAU	0.3%	0.6%	0.3%	5.4%

**1: Category not used for MHC services

**2: Hispanic origin may be of any race.
This population also counted in other groups.

- Identify and promote strategies for recruitment and retention of persons from diverse cultural groups at all levels in the mental health service delivery system.

- Make sure that mental health professional education includes content on issues of cultural diversity.

- Set a standard for hiring mental health professionals who have prior training in cultural diversity, or provide cultural diversity training as part of their initial orientation.

- Hold accountable administrative and provider organizations for promoting cultural competence and value diversity in board membership, hiring, services, purchasing, training/inservicing, and the mechanisms for the ongoing evaluation of these areas.

Training on cultural diversity should only be provided by persons who are prepared in this area, by at least two persons who represent more than one cultural viewpoint, in a manner that allows adequate time for the topic, and without reinforcing stereotypes.

In addition, similar efforts should be made to address the specialized needs of elders who have mental disorders. National research indicates that elders significantly under-utilize formal mental health services. A variety of reasons are given for this trend. These include ageism in the profession; difficulty in access because of limited availability of transportation services; financial limitations; difficulty in securing staff who are knowledgeable about both geriatric and mental health issues; and client prejudice against the mental health system (Chinlund, 1991; Hagebok & Hagebok, 1983). As implementation proceeds with this Master Plan and with the Department on Aging Plan for Specialized Services for Elders with Mental Health Needs (see Appendix C), actions to address the HRD and Cultural Competence issues discussed above also need to actively include a focus on provision of specialized services for elders.

CONSUMER INVOLVEMENT

Note: The recommendations contained in this section were primarily developed by a workgroup of the Mental Health Plan Advisory Committee, and thus, directly reflect the values and desires of relevant constituencies in Milwaukee County.

People with direct experiences in the mental health/illness system (as either ex-patients or active service recipients) and their family members have unique contributions to make toward improving the quality and function of the mental health system. They are the most knowledgeable resources for providing information about what is working well and what needs to be improved. The mission statement for the Milwaukee Mental Health System reflects the importance of consumer involvement in all areas of the mental health system.

As stated in this Mission statement, a primary goal of the system should be the promotion of positive images of people with psychiatric disability through the use of appropriate non-stigmatizing language, opportunities for making positive contributions, and employment.

Governance

Consumers should have active and vital roles in the agencies and organizations which collectively constitute the mental health system. To realize this goal, the involvement of consumers as board members should be mandated for all mental health agencies receiving a majority of their funds through the Adult Mental Health Division. Initially, the number of consumers per agency should be at least two, but agencies should establish as a goal 50% consumer governing board membership. This also should be a requirement for any committee or board of the Adult Mental Health Division, including the Master Plan Advisory Committee and the Combined Community Services Board.

This involvement of consumers must be assured through the provision of supports. These supports must be financial in the form of stipends, a per diem and/or funds to assist with transportation cost. Functional supports should also be made available for consumers. Functional supports might include preparation for meetings or post meeting follow-up.

System Feedback and Evaluation

The mental health system should establish on-going mechanisms for obtaining and updating information to gain insight about its effectiveness and the needs of consumers.

One such mechanism is to formally and regularly obtain written information from active ex-patient/consumer and family organizations related to their concerns about the mental health system. These formal assessments should solicit consumer and family recommendations about ways for improving services.

In addition, the administrative staff of the Adult Mental Health Division and of provider agencies should establish regular meetings with local family and consumer groups on a monthly or bi-monthly basis. This allows the key decision-makers within the system to have direct information about service improvements and needs.

Consumers and family members also should be included in the design and implementation of service evaluation activities, and a component in evaluating mental health provider agencies should include their efforts at updating and obtaining information about the needs of consumers.

Employment

The system should have as a value the employment of consumers of mental health services, in ways that are not nominal or that promote tokenism. Within the context of this employment, consumers should have assess to supportive work environments and climates.

To realize this value, the agencies should be encouraged to create jobs specifically for consumers. In addition, paraprofessional training programs must be developed that have as a goal the transfer of consumer paraprofessionals into professional staff positions. To adequately support consumer staff, procedures must be developed for assuring reasonable accommodation. Non-consumer staff also may need on-going training or other mechanisms for exploring the usefulness of, and how to provide assistance with, the integration of consumer staff into the workforce.

In order to assist with the above efforts, and to assure that consumer involvement is at the forefront of all activities of the Adult Mental Health Division, it is recommended that a Consumer Affairs Specialist be hired within the Division. In addition to the above activities, this staff would help consumers throughout the county develop support groups, respond to Requests for Proposals to provide consumer-operated services, and so forth. A budget of $48,900 has been allocated to the DHS reorganization costs to assist with these activities.

SUMMARY

The service system outlined in this chapter is one that is derived from the Vision, Mission and Guiding Principles set forth by the Master Plan Advisory Committee. It is based on the experiences of model system throughout the country, but is adapted to reflect the culture, values and existing service system in the county of Milwaukee. This service system would enable Milwaukee County to assists its citizens with mental illness to have full lives, and to prevent them from having to reach the point of crisis before receiving services. It also would provide the administrative supports to assure a system that is efficient, effective, and responsive to the needs of its consumers and the needs of its staff.

CHAPTER FIVE:

FISCAL PLAN

INTRODUCTION

This Plan does not include services for children and youth or for persons with developmental disabilities. As such, the fiscal analyses are based only on revenues that are directly related to the public sector adult mental health system, which includes MHC services for adults with mental illness, private contract agencies that received funds from ASD to provide adult mental health services, and the revenues collected by the private contract agencies themselves which supported their adult mental health services.

All of the proposed changes in Chapter Five can be achieved with the same amount of revenues available in the Milwaukee County public sector adult mental health system in FY1992, with two exceptions. First, there may be outstanding crosscharges currently incurred by MHC that would no longer be needed within the mental health system, and this may have an impact on other county organizations or departments. In addition, revenues are not included for the one-time costs of approximately $2,208,000 to develop the proposed Management Information System for the adult mental health system, including MHC and contract agencies. With these two exceptions, redistribution of *existing* revenues, plus new tax levy dollars approved in November, 1993 by the County Executive to be allocated over the next five years for a Lawsuit Settlement, would enable the County of Milwaukee to implement all of the recommendations in Chapter Five, including the proposed new or enhanced services; the DHS administrative reorganization; funds for staff training, consumer involvement, service evaluation activities, and on-going maintenance of the MIS; and an allocation to fund crosscharges purchased by MHC in FY92 which would continue to be needed within the adult mental health system, regardless of MHC service capacity.

This Chapter presents the methodology used to calculate the revenues needed to fund the proposed service system, including the assumptions made for costs of the service components and administrative structures and other supports; assumptions for revenue sources and the proposed shifts from FY1992; an overall comparison of revenues for FY1992 and the proposed system, and implications for the service delivery system and Milwaukee tax payors; and, discusses other fiscal issues that should be addressed to maximize public sector services for adults with mental illness in Milwaukee County.

METHODOLOGY FOR FISCAL ANALYSES

SERVICE REVENUES

Existing Service Components

Information on service revenues allocated by the Adult Service Division and other service revenues received by contract agencies was provided by the Mental Health Bureau. Information on service revenues received by the Mental Health Complex was provided by this organization's fiscal department. All revenue information for existing services was based on year-end FY1992 reconciled budgets. All revenue projections were based on non-inflationary dollars.

For most of the service components that already exist in Milwaukee County, projections for proposed service revenue were based on FY92 revenue (according to all revenues reported for that service) per person served by the service. Revenues, rather than service costs, were used for the fiscal analyses since this information was much more readily accessible. Often revenues may exceed or be less than actual cost for a particular service; when this occurs, agencies often use excess revenue generated by one service to cover the cost of services which did not receive enough revenue within the fiscal year, or they rely on tax levy funds to balance the revenue/cost ratio. As such, the fiscal analyses in this plan do not reflect actual cost of each service, but rather the revenue generated by this service (including tax levy funds). By using end-of-the-year revenue summaries, the fiscal analyses do reflect total revenues across all services within the public sector adult mental health system, and, as such, revenues for the overall adult mental health service system should equal adult mental health service system cost.

On the advice of Mental Health Bureau staff, projected revenues for CSP services were based on the revenues of a certified CSP in the County which is considered to be of high quality, according to its state certification review. This revenues per person ratio was used to project proposed CSP revenues with the expectation that all CSP services within the County would be certified, and that they also would achieve this level of quality by the end of the proposed plan. In essence, using this revenues per person resulted in a higher revenues projection for CSPs than would have occurred if the average revenues per CSP client across all existing certified CSPs was used.

As shown in Table 7, projected revenues for inpatient services were pro-rated based on FY92 revenues per bed, with the exception of Rehabilitation beds. In this case, a higher amount was used due to higher fixed administration and support costs.

Table 7

PROPOSED INPATIENT REVENUE SAVINGS & REDISTRIBUTION

PROFILE OF FY1992 INPATIENT REVENUE SOURCES

INPATIENT SERVICES	Bed Capacity	TOTAL REVENUE	COMMAIDS	TAX LEVY	IMD	T-18	FED-STATE T-18/T-19	FED-STATE T-19	MCHCP	SELF PAY	MISC
Acute: General	96	$21,308,607	$0	$3,589,408	$0	$5,430,702	$1,450,422	$923,208	$7,583,987	$1,273	$2,329,607
Geropsych Acute	48	in acute									
Dual Diagnosis (MI/SA)	55	in acute									
Rehab	320	23,063,633	386,688	9,490,325	7,012,505	80,000	110,000	5,087,350	0	167,598	729,167
Doyle Hospital Units	48	4,404,103	0	873,306	0	0	0	0	0	0	3,530,797
Westview Nursing Home	4	56,861	0	0	56,861	0	0	0	0	0	0
Wisconsin State Institute	4	363,632	292,594	71,038	0	0	0	0	0	0	0
INPATIENT SUBTOTAL	575	49,196,836	679,282	14,024,077	7,069,366	5,510,702	1,560,422	6,010,558	7,583,987	168,871	6,589,571
(Less Neg Tax Levy Charges)		(4,627,140)		(4,627,140)					0		
INPATIENT TOTAL	575	$44,569,696	$679,282	$9,396,937	$7,069,366	$5,510,702	$1,560,422	$6,010,558	$7,583,987	$168,871	$6,589,571

PROPOSED INPATIENT CAPACITY and RESULTING REVENUE

INPATIENT SERVICES	Bed Capacity	TOTAL *** REVENUE	COMMAIDS	TAX LEVY	IMD	T-18	FED-STATE T-18/T-19	FED-STATE T-19	MCHCP	SELF PAY	MISC
Acute: General	60	$11,722,630	$0	$1,816,043	$0	$3,153,854	$844,883	$473,536	$4,082,934	$743	$1,350,636
Geropsych Acute	24	in acute									
Dual Diagnosis (MI/SA)	24	in acute									
Rehab	84	6,720,000	112,668	3,759,988 *	1,048,405 *	23,309	32,050	1,482,290	0	48,833	212,456
Doyle Hospital Units	48	4,404,103	0	873,306	0	0	0	0	0	0	3,530,797
Westview Nursing Home	0	0	0	0	0	0	0	0	0	0	0
Wisconsin State Institute	5	450,000	362,089	87,911	0	0	0	0	0	0	0
INPATIENT SUBTOTAL	245	$23,296,733	$474,757	$6,537,248	$1,048,405	$3,177,163	$876,933	$1,955,826	$4,082,934	$49,576	$5,093,889

NET INPATIENT SAVINGS

INPATIENT SERVICES	Bed Reduced	TOTAL SAVINGS	COMMAIDS	TAX LEVY	IMD	T-18	FED-STATE T-18/T-19	FED-STATE T-19	MCHCP	SELF PAY	MISC
Acute: General	36	$9,585,977	$0	$1,773,365	$0	$2,276,848	$605,539	$449,672	$3,501,053	$530	$978,971
Geropsych Acute	24	in acute									
Dual Diagnosis (MI/SA)	31	in acute									
Rehab	236	16,343,633	274,020	5,730,337	5,964,100	56,691	77,950	3,605,060	0	118,765	516,711
Doyle Hospital Units	0	0	0	0	0	0	0	0	0	0	0
Westview Nursing Home	4	56,861	0	0	56,861	0	0	0	0	0	0
Wisconsin State Institute	-1	(86,368)	(69,495)	(16,873)	0	0	0	0	0	0	0
(Less Neg Tax Levy Charges)		(4,627,140)		(4,627,140)							
INPATIENT SUBTOTAL	330	$25,900,103	$204,525	$2,859,689	$6,020,961	$2,333,539	$683,489	$4,054,732	$3,501,053	$119,295	$1,495,682

RESULTING TRANSFERS FOR COMMUNITY SERVICES **

INPATIENT SERVICES	TOTAL TRANSFERRABLE	COMMAIDS	TAX LEVY	IMD	T-18	FED-STATE T-18/T-19	FED-STATE T-19	MCHCP	SELF PAY	MISC
Acute: General	$1,773,365		$1,773,365							
Geropsych Acute										
Dual Diagnosis (MI/SA)	$0									
Rehab	$11,968,457	$274,020	$5,730,337	$5,964,100						
Doyle Hospital Units										
Westview Nursing Home				$56,861						
Wisconsin State Institute	($86,368)	($69,495)	($16,873)							
(Less Neg Tax Levy Charges)	($4,627,140)		($4,627,140)							
TOTAL	$9,028,314	$204,525	$2,859,689	$6,020,961	$0	$0	$0	$0	$0	$0

ASSUMPTIONS:

* This amount is determined on the basis of $95 per bed day agreement with State of Wisconsin. Because the historical revenue data supports only about $87/bed/day, the difference is made up in the Tax Levy Revenue.

** Only Community Aids, Tax Levy and IMD revenue sources are assumed to be transferrable for Community Services.

*** Total Revenues for proposed bed capacity were prorated except for REHAB ($80,000 per bed was used due to higher fixed administration and support costs).

Proposed Service Components

The calculations for service components which do not exist in Milwaukee County are summarized in Table 8. Salary and fringe amounts were derived according to estimates provided by the Adult Services Division (ASD).

Coordination with the Department on Aging Plan for Elders Mental Health Needs

As noted in Chapter Two, the reorganization which created the Department of Human Services also created the new Department on Aging (MCDA), with responsibility for all human services for adults age 60 and older. As part of this effort, it was agreed that resources supporting Adult Service Division clients age 60 and older would be transferred to the MCDA; however, no date has been set for this transition.

As can be seen from the MCDA Plan for Specialized Services for Elders with Mental Health Needs (Appendix C), many of the services and approaches proposed in this plan are similar to those desired by MCDA. For the purposes of the fiscal analyses contained in this plan, it was assumed that the MCDA would use existing mental health funds it receives from the agreed-upon transfer to contract for many of the services proposed in this plan, or that it would independently develop and fund similar services. As such, the net effect on the resources to provide public sector mental health services to people with mental illness in Milwaukee County is equalized within this proposal.

Administration, Support Costs

There are several cost centers proposed in this plan which are not related to the direct service components. These include costs for the reorganization of the Department of Human Services, costs associated with the implementation and maintenance of a system-wide Management Information System, changes in the County Crosscharges incurred by the Mental Health Complex, and implications for the MHC workforce.

Department of Human Services Reorganization: As shown in Table 6 of Chapter Four, the costs associated with this reorganization are based on FY92 staffing and salary ranges within the ASD Mental Health Bureau.

Management Information System: The basis of the cost estimates associated with the implementation of this system, and with the on-going maintenance of this system, are discussed in Chapter Four and displayed in Table 6.

Table 8

NEW SERVICE COMPONENT COST CALCULATIONS

SERVICE	STAFF /SHIFT	SHIFTS /WK	HRS /WK	FTEs	SUBST FTEs (.16)	TOTAL FTEs	STAFF LEVEL	SALARY LEVEL	W/ .35 FRINGE	TOTAL STAFF COST	ADMIN/ SPACE	TOTAL COST
24 Hr Information/Triage #	1	21	168	4.2	0.7	5	MA/RN	$31,000	$41,850	$203,893	$40,779	$244,672
Community Assessment Prg	1.75	21	294	7.35	1.2	9	PhD/RN /MSW	$35,667	$48,150	$410,527	$41,053	$451,580
24 Hr Crisis Hotline	1	21	168	4.2	0.7	5	MA/RN	$31,000	$41,850	$203,893	$40,779	$244,672
Assist Team	2	14	224	5.6	0.9	6	MHTech	$21,000	$28,350	$184,162	$18,416	$202,578
Respite Apartment	1	21	168	4.2	0.7	5	BA	$24,000	$32,400	$157,853	$22,985	$180,838
Crisis Respite Apartment	1	21	168	4.2	0.7	5	BA	$24,000	$32,400	$157,853	$22,985	$180,838
Mental Health Police Liaison	1	21	168	4.2	0.7	5	MA/RN	$31,000	$41,850	$203,893	$40,779	$244,672
Crisis Specialists	2	21	336	8.4	1.3	10	BA	$24,000	$32,400	$315,706	$31,571	$347,276
Mobile Crisis Team	3	21	504	12.6	2.0	15	MA/RN	$31,000	$41,850	$611,680	$61,168	
	0.25	21	42	1.05	0.2	1.25	MD	$90,000	$121,500	$151,875		$824,723

County Services Crosscharges: Because the Mental Health Complex (MHC) is a county-run organization, it receives services from other county agencies to provide a number of support services. As such, reduction in services provided by MHC could affect the overall county budget by reducing the crosscharges incurred by MHC since it would no longer need as much of these supports. Assuming that the County does not want to reduce its workforce to reflect reduction in county-operated services (which may not be an efficient economic assumption for the County), these additional costs would need to be incurred by other county-operated services.

Table 9 presents the effect of the proposed plan on the MHC crosscharges, based on FY92 data. Column 2, 1992 Actual, shows the crosscharges paid by MHC to the various other county-operated services in FY92, which totals $11,384,437. Column 3, MHC Adult Services Share, reflects the fact that MHC provides services to adults and to children and youth and people with developmental disabilities. As such, the crosscharges associated with the adult mental health services only were calculated, based on the proportion of total MHC revenues which were allocated for the adult services contained in this plan (72.7%). Column 4, Crosscharges covered by MHC Services in FY99 Plan, calculates the crosscharges which would still be needed by MHC in the proposed service system, and therefore are already included in the proposed service system revenue estimates ($3,816,813). In addition, some of the remaining crosscharges are for services that would continue to be needed within the adult mental health system regardless of whether services are provided by MHC or other agencies, such as services provided by Corporation Counsel. The fiscal analyses of this plan assumes that these crosscharges ($841,073) would continue to be an expense of the system, but are not reflected in any projected revenues for direct services. Therefore, $841,073 is allocated within the fiscal analyses to pay for these crosscharges. The remaining crosscharges ($3,613,759) would need to be assumed by other county organizations (if the above assumption about maintaining existing county employee numbers is correct).

The revenue allocation in this proposal does not address the $3,613,759 in outstanding crosscharges. There are several ways to approach these outstanding crosscharges. First, the above assumption about the county not wanting to proportionately reduce the expenses of these crosscharge services as some county-operated services change in size and/or need may be fallacious. Second, if the Mental Health Complex or any other county-operated agencies provides any of the proposed services which are in addition to, or more of, the services provided by MHC, a proportion of the outstanding crosscharges will be incurred by these proposed services. As for the crosscharges associated with building maintenance and security, as MHC downsizes, it is entirely possible that any vacant buildings could house other county-operated programs or services, especially for the Main Campus, which is co-located with the comprehensive County Medical Complex.

Table 9

EFFECT OF PROPOSED PLAN ON MCMHC BUDGET CROSSCHARGES

Line Item	1992 Actual	MHC Adult Services Share (.727) *	Crosscharges Covered by MHC Services in Proposed Plan **	Crosscharges Not Covered by MHC Services in Proposed Plan **	Crosscharge Svcs Needed w/in Overall Proposed Adult M H System
Visual Comunication Service	27,981	20,330	9,381	10,949	
Information Process Service	53,405	38,803	17,905	20,898	20,898
CAMD Services (Vehicles)	141,948	103,136	47,590	55,546	
Park Services Division	80	58	27	31	
Pro Services Division	801	582	269	313	
Sheriff Services (patrolling)	983,154	714,335	329,618	384,717	
Corporation Counsel Services	138,819	100,862	46,541	54,321	54,321
Park Region Services	4,391	3,190	1,472	1,718	
Mail Room Services	6,740	4,897	2,260	2,637	
Risk Management Services	41,904	30,446	14,049	16,397	
Inst - Accounting Services	10,536	7,655	3,532	4,123	4,123
Securities Division (claims collection)	100,138	72,758	33,573	39,185	39,185
DHHS Data Center Charge (processin	1,004,369	729,749	336,731	393,019	393,019
Institutes Administration (DHS Admin	184,925	134,362	61,999	72,363	72,363
Bakery	158	115	53	62	
Laundry	329,182	239,175	110,363	128,812	
Engineering Building Maintenance	1,447,138	1,051,454	485,176	566,278	
Fire Protection	119,572	86,878	40,088	46,790	
Grounds Maintenance	324,594	235,842	108,825	127,017	
Institutes Traffic Division	345,774	251,231	115,926	135,304	
Power Plant chilled Water	778,156	565,389	260,889	304,499	
Power Plant Electric	680,818	494,665	228,255	266,410	
Power Plant Sanitary Sewer	69,720	50,657	23,375	27,282	
Power Plant Steam	825,425	599,733	276,737	322,996	
Power Plant Water	153,128	111,259	51,339	59,920	
Oper Maintenance Plant	65,586	47,653	21,989	25,664	
Medical Services MCMC	501,108	364,092	168,004	196,088	196,088
Dietary Services	32	23	11	13	
Prof St & Suppt - Medical Records	156,084	113,407	52,330	61,077	61,077
Worker Comp - Med & WC Pay	457,832	332,649	153,495	179,154	
Telephone Allocation	338,265	245,775	113,409	132,366	
Insurance Services	213,670	155,247	71,636	83,611	
Workers Compensation Admin	4,017	2,919	1,347	1,572	
Central Service Allocation (Co Admin)	1,159,414	842,401	388,712	453,689	
Interest Allocation (Bonds interest)	598,427	434,802	200,632	234,170	
CH Complex Space Rental	16,381	11,902	5,492	6,410	
Record Center Services	15,492	11,256	5,194	6,062	
Dependant Care	7,074	5,140	2,372	2,768	
Other County Services	78,199	56,817	26,217	30,600	
TOTAL CROSSCHARGES	$11,384,437	$8,271,645	$3,816,813	$4,454,832	$841,073
			OUTSTANDING CROSSCHARGES (To be assumed by other County organizations or increased County MH services)		$3,613,759

* Extracts Proportionate Share for CATC and Rehab South (MR) Services
** Extracts Proportionate Share Covered by Remaining MCMHC Adult Services

CALCULATIONS:
* (Adult - (CATC & Rehab South)) / Total MCMHC = 72.7% $65,857,963

** W/in MHC Adult Mental Health Services total, some cost centers stay at same level of funding;
total of these costs w/in total adult services budget = crosscharges covered by proposed plan
(CSP+COP+CCLP+Forensic+Gero Outpt+Breakaway $$$) = $3,428,583

Other MHC Adult Mental Health costs centers are reduced by various proportions;
% of these costs centers remaining w/in total adult service budget = crosscharges covered by proposed plan
((Inpt(240/567) x Inpt $) + (Outpt(4822/9395) x Outpt $) + (Day Tx(606/939) x Day Tx $)) + (PCS (2499/8707) x PC$ $26,960,476

MHC Staffing Needs

In FY92, there were 1,702.5 FTEs employed at the Milwaukee County Mental Health Complex. Of these, approximately 767 provided direct care on the adult inpatient units. With the proposed reductions in this plan, approximately 315 of these direct care staff might be affected by the inpatient downsizing. (It should be noted that a number of FTEs have already been decreased due to the downsizing efforts which have occurred since the end of FY92 and which are planned for FY94; these FTEs are a portion of the 315 FTEs referred to above).

As noted in Chapter One, many areas around the country have successfully downsized without having staff layoffs, through natural attrition, vacancies, and aggressive redeployment strategies to community-based services. It is recommended that actions be taken immediately to educate MHC inpatient staff about the direction of the Master Plan for two purposes: (1) to help them understand the rationale behind the plan's recommendations and dispel any myths about the proposed service shifts that may have occurred during the planning project, and (2) to begin a process of identifying staff who may be interested in providing community-based care. The service enhancements continued in this plan will require a significant increase in the workforce within the overall public mental health system, and the skills and expertise of many of the inpatient staff would be an asset to the quality of service delivery. They would especially be valuable staff for CSPs and case management focused on the needs of people discharged from inpatient settings.

In addition to direct care staff, MHC administrative and maintenance personnel also may be affected by the proposed service shifts. It is very difficult to project this impact, however, since many of these staff would continue to be needed if MHC were to increase its provision of the recommended community-based services, such as CSPs, case management, psychosocial rehabilitation programs, and so forth.

REVENUE SOURCES AND PROPOSED SHIFTS

The charge given to the consultants for the development of this Master Plan by the Department of Human Services was to base the financial analyses on the assumption of level funding (i.e., that no new resources would be available from county revenue sources). In addition, the consultants assumed that reimbursement rates for Federal and State funds would not change from those available at the time of conducting the fiscal analyses for the plan (June through November, 1993). All revenue projections were based on non-inflationary dollars.

Following is a definition of each revenue source contained within the fiscal analyses, as well as an explanation of the assumptions used to project proposed service revenues and the resulting revenue shifts for each revenue category (see Table 10).

Table 10

COMPARISON OF FY92 AND PROPOSED REVENUE TOTALS BY SOURCE

REVENUE SOURCE	FY1992 COMMUNITY	FY1992 INPATIENT	FY1992 TOTAL	PROPOSED COMMUNITY	PROPOSED INPATIENT	PROPOSED NEW ADMIN	PROPOSED TOTAL	NET CHANGE (PROPOSED–FY92)
CSP–STATE	$500,627		$500,627	$500,627			$500,627	$0
MENTAL HEALTH BLOCK GRANT	$67,294		$67,294	$67,294			$67,294	$0
COMMUNITY AIDS	$21,346,948	$679,282	$22,026,230	$21,551,473	$474,757		$22,026,230	$0
TAX LEVY	($4,204,532) a	$14,024,077 a	$9,819,545 a	$3,038,406	$6,537,248	$2,092,355	$11,668,009	$1,848,464 b
FEDERAL FORENSIC	$182,464		$182,464	$182,464			$182,464	$0
IMD	$472,720	$7,069,366	$7,542,086	$6,493,681	$1,048,405		$7,542,086	$0
FEDERAL PATH FUNDS	$181,015		$181,015	$181,015			$181,015	$0
GOVERNMENT PURCHASE	$753,511		$753,511	$542,677			$542,677	($210,834)
TITLE 18	$962,623	$5,510,702	$6,473,325	$2,315,378	$3,177,163		$5,492,541	($980,784)
TITLE 18/TITLE 19	$1,314,901	$1,560,422	$2,875,323	$930,995	$876,933		$1,807,928	($1,067,395)
FEDERAL TITLE 19	$213,615		$213,615	$8,968,924			$8,968,924	$8,755,309
FEDERAL–STATE TITLE 19	$3,842,077	$6,010,558	$9,852,635	$2,268,382	$1,955,826		$4,224,208	($5,628,427)
FEDERAL–LOCAL TITLE 19	$354,691		$354,691	$457,233			$457,233	$102,542
HEALTH CARE FINANCING PLAN	$880,464	$7,583,987	$8,464,451	$880,464	$4,082,934		$4,963,398	($3,501,053)
COP	$921,706		$921,706	$921,706			$921,706	$0
SELF PAY	$1,625,739	$168,871	$1,794,610	$1,088,887	$49,576		$1,138,463	($656,147)
MISCELLANEAOUS	$1,898,364	$6,589,571	$8,487,935	$2,293,471	$5,093,889		$7,387,360	($1,100,575)
TOTAL W/O NEW ADMIN COSTS	$31,314,227	$49,196,836 a	$80,511,063	$52,683,077	$23,296,733		$75,979,810	
% OF TOTAL REVENUES	38.9%	61.1%		69.3%	30.7%		100%	
TOTAL WITH NEW ADMIN COSTS				$52,656,888	$23,296,733	$2,092,355 c	$78,072,165	($2,438,900)
% OF TOTAL REVENUES				67.4%	29.8%	2.6%		

a Accounts for $4,627,140 in Tax Levy revenue targeted for community based services, but applied to inpatient services, by MCMHC

b Amount of new Tax Levy apporved for Law Suit Settlement to be allocated over five year period

c New Admin costs include:

$338,360	DHS Reorganization (New Staff)
$398,900	DHS Reorganization (Consumer Aolitvities, Staff Training, Service Evaluation)
$513,992	MIS On–Going Maintenance
$841,073	Outstanding County Cross–charges needed by Mental Health System, but not allocated to specific service components
$2,092,355	

CSP-State

These are monies administered by the state mental health agency, and are used to reimburse for CSP services according to regulated standards. For the fiscal analyses, these revenues were not prorated based on increase in service delivery, and were not assumed to be transferrable across service components.

As can be seen in Table 10, the revenue from this source projected for the proposed service system was the same as that available for FY92: $500,627

Mental Health Block Grant Funds

These also are federal monies administered by the state mental health agency, and can only be used for service components approved by the State Bureau of Mental Health. For the fiscal analyses, these revenues were not prorated based on increase in service delivery, and were not assumed to be transferrable across service components.

As can be seen in Table 10, the revenue from this source projected for the proposed service system was the same as that available for FY92: $67,294

Community Aids

These are state and federal funds distributed by the Department of Health and Social Services to counties to provide human services. With a few exceptions, the use of these funds is at the discretion of the County; as such, these funds were assumed to be transferrable across service components. They were not prorated based on increased service delivery.

The amount of this revenue source was held constant within the fiscal analyses: $22,026,230.

County Tax Levy

These are funds generated by county taxes, and are allocated at the discretion of the county. These funds were assumed to be transferrable across service components, and they were not prorated based on increased service delivery.

With the exception of adding $1,848,464 in new tax levy dollars approved by the County Executive in November, 1993 to be allocated over the next five years to fulfill a lawsuit settlement, the amount of this revenue source was held constant within the fiscal analyses: $1,848,464 + $9,819,545.

Forensic Funds

These are special forensic services funds administered by DHS. For the fiscal analyses, these revenues were not prorated based on increase in service delivery, and were not assumed to be transferrable across service components.

The revenue from this source projected for the proposed service system was the same as that available for FY92: $182,464.

Institute for Mental Disease (IMD) Funds

Federal regulations state that there can be no Medicaid reimbursement for services received by persons between the ages of 21 and 64 in inpatient or nursing home settings that primarily serve people with mental illness. (Children and youth under the age of 21 are eligible for Medicaid and adults age 65 and older are eligible for Medicare and Medicaid health care coverage). The State of Wisconsin developed an Institute for Mental Disease Fund to reimburse inpatient settings for these services. Recently, the state also has agreed to allow, for each inpatient bed closed, the transfer of these funds to community-based services at the rate of $95 per bed day, so these funds were assumed to be transferrable across service components. However, because the historical data in this analyses indicated a bed day reimbursement level of $87 per bed per day, the difference was made up in the Tax Levy revenue source.

The revenue from this source projected for the proposed service system was the same as that available for FY92: $7,542,086.

Federal PATH Funds

These are federal funds distributed by the State Bureau of Mental Health to be used for specialized homeless programs and services. For the fiscal analyses, these revenues were not prorated based on increase in service delivery, and were not assumed to be transferrable across service components.

The revenue from this source projected for the proposed service system was the same as that available for FY92: $181,015.

Government Purchase Revenues

These dollars represent revenue received by agencies for services provided to consumers of other agencies located outside of the County or state. These revenues were prorated based on proposed revenues for service vs. FY92 revenues for service. They were not assumed to be transferrable across service components.

The revenue projected from this source for the proposed service system decreased by $210,834 from that available in FY92.

Title 18

Title 18 (Medicare) is a federal entitlement which covers hospital and medical insurance for all persons aged 65 years and over who are eligible for Social Security, have been receiving Social Security Disability Insurance (SSDI) payments for at least two years, or have end-stage renal disease. For the current analyses, Title 18 revenues were prorated based on proposed revenues for service vs. FY92 revenues for service. They were not assumed to be transferrable across service components.

The revenue projected from this source for the proposed service system decreased by $980,784 from that available in FY92.

Title 18/Title 19

This category represents payment for services where the client is eligible for both Medicare and Medicaid. These revenues were prorated based on proposed service revenues vs. FY92 service revenues. They were not assumed to be transferrable across service components.

The revenue projected from this source for the proposed service system decreased by $1,067,395 from that available in FY92.

Title 19

Title 19 (Medicaid) is a joint federal-state program that pays medical bills for low-income persons who become eligible through receipt of federal income assistance from one of two programs: Aid to Families with Dependent Children (AFDC) or Social Security Income (SSI) for people who are blind, aged, and disabled. The federal law requires that each state offer nine specified services, and provides guidelines for optional services that can be covered. It specifically excludes services provided in an Institute for Mental Diseases (see Institute for Mental Disease above). Each state can determine the optional benefits that will be offered, but typically impose limitations on the amount, duration, and scope of services that will be covered. In addition, because Medicaid guidelines allow limited outreach service coverage, there is a "perverse incentive" for using facility or office-based services. Many states have negotiated to create "waivers" to allow outreach services to also be covered, based on a rationale that this is a more cost effective approach for care.

In this analysis, Title 19 revenue represents the federal share of Medicaid payments for CSP and Targeted Case Management services. They were not assumed to be transferrable across service components. In order to project proposed revenues from this source for these two service components, the following formulas were used, per the direction of Shell Gross, Wisconsin Medicaid Agency:

CSP
12 (mo) x $250 (statewide organization monthly per Medicaid eligible client payment for CSP) x number of clients x .6 (proportion of Medicaid eligible clients - statewide)

Targeted Case Management
Number of case managers x productivity factor (.6 x 2080) x $19.54 (applicable payment rate) x .6 (Medicaid client eligibility rate)

The revenue projected from this source for the proposed service system increased by $8,755,309 from that available in FY92.

Federal-State Title 19

This category represents Medicaid payments where federal and state share are combined. These revenues were prorated based on proposed service revenue vs. FY92 service revenue. They were not assumed to be transferrable across service components.

The revenue projected from this source for the proposed service system decreased by $5,628,427 from that available in FY92.

Federal-Local Title 19

This category represents Medicaid payments where eligible county funds are used to match Federal Financial Participation (FFP). With the exception of CSPs, these revenues were prorated based on proposed revenues for service vs. FY92 revenues for service. They were fixed for CSP services because of the projected Medicaid for these services under Title 19. None of this revenue was assumed to be transferrable across service components.

The revenue projected from this source for the proposed service system increased by $102,542 from that available in FY92.

Milwaukee County Health Care Financing Program

These are state and county monies used for medically indigent health and psychiatric care. With the exception of the reduction in inpatient services, these revenues were fixed at the FY92 allocation level across each service component, and were not considered transferrable.

Due to the proposed decrease in inpatient services, the revenue from this source projected for the proposed service system decreased by $3,501,053 from that available in FY92.

Community Options Program (COP)

The Community Options Program (COP) was created by the 1981-83 biennium Wisconsin budget act to provide funds for home and community based services to people seeking or at imminent risk of placement in a nursing home or one of the three state centers for people with developmental disabilities. COP funds are intended to be used for assessment, case planning and service provision, and can only be used after other available resources have been accessed. For the fiscal analyses, these revenues were not prorated based on increase in service delivery, and were not assumed to be transferrable across service components.

The revenue from this source projected for the proposed service system was the same as that available for FY92: $921,706

Self Pay

These revenues represent payments from clients charged for services. For the fiscal analyses, these revenues were prorated based on the proposed clients served vs. those served in FY92. These revenues were not assumed to be transferrable across service components.

The revenue from this source projected for the proposed service system decreased by $656,147 from that available for FY92.

Miscellaneous

This revenue category represents all other funding sources not described above. With the exception of risk reduction program, these revenues were prorated based on increased service delivery. Because risk reduction programs do not receive revenue based on numbers of clients served, the miscellaneous revenues for these programs were pro-rated at a projected 50% increase over FY92 miscellaneous revenues, while the actual increase in other revenue was 550%. (If the same proration was used for these programs as for the other service components, it would have resulted in a projected increase of an additional $233,750 in miscellaneous revenues, which did not seem to be an appropriate expectation for these types of programs). None of these revenues were assumed to be transferrable across service components.

The revenue from this source projected for the proposed service system decreased by $1,100.575 from that available for FY92.

REVENUE COMPARISONS AND IMPLICATIONS

Based on the above methodological assumptions and calculations, all of the recommended changes in Chapter Five can be achieved with the same amount of revenues available in the Milwaukee County public sector adult mental health system in FY1992, with the exception of the addition of already approved new tax levy dollars which are needed to address a lawsuit settlement, and the one-time costs of approximately $2,208,000 to develop the proposed Management Information System. As shown in Table 10, this proposed service system requires no other new resources from the County of Milwaukee. In fact, resources allocated from the Health Care Financing Program Fund are projected to decrease by $3.5 over the next five years. Since Health Care Financing Program funds are County Tax Levy dollars, there actually is a projected direct savings of approximately $1,926,000 for the citizens of Milwaukee.

Tables 11 through 15 provide detailed information about the service needs, revenues, and revenue sources for the service system proposed in this Master Plan. Table 11 shows the assumptions of need for each proposed service component by each of the target populations. As can be seen in Table 11, the estimated revenues per person is the highest for Target Group 1, and decreases proportionately for each of three next groups. This reflects the proposal in this plan to target the most resources on those individuals with the most severe needs.

Table 12 presents the proposed revenue shifts to achieve the services described in the Master Plan, and based on the assumptions of service need presented in Table 11.

Table 13 provides a comparison of the FY92 and proposed revenue distribution by service category. As is evident from this table, the proposed plan would result in a shift from allocating 61% of the system's resources on inpatient services to allocating 69% of the resources on community-based services.

Table 14 provides a more detailed comparison of this proposed shift in revenue allocation, indicating the proposed change in revenue for each service component.

Table 15 shows the implications of the proposed shifts on use of each of the revenue sources. As is evident from this Table, the proposed fiscal plan would shift in the use of federal and state funds (i.e., Medicaid/Medicare, IMD) to primarily support community-based rather than inpatient services. In addition, a much lower percentage of Tax Levy and Health Care Financing Program funds would be used to support inpatient services - which are extremely expensive, intrusive, and an indication of poor services to prevent crises and hospitalization - and a higher percentage would be used to support more proactive and humane community-based services which can assist Milwaukee County's citizens with mental illness to achieve much more productive and meaningful futures.

Table 11

PROPOSED MILWAUKEE COUNTY MENTAL HEALTH SERVICE NEEDS AND REVENUES BY TARGET POPULATION GROUPS

SERVICE COMPONENT	"Unit" Definition	Proposed Annual Rev/"Unit"	ALL POPS # of Clients	ALL POPS Proposed Revenue Total	TARGET POP 1 = 4,753 % of Pop	TARGET POP 1 # of Clients	TARGET POP 1 "Unit" Need	TARGET POP 1 Total Revenue	TARGET POP 2 = 1,459 % of Pop	TARGET POP 2 # of Clients	TARGET POP 2 "Unit" Need	TARGET POP 2 Total Revenue	TARGET POP 3 = 4,996 % of Pop	TARGET POP 3 # of Clients	TARGET POP 3 "Unit" Need	TARGET POP 3 Total Revenue	TARGET POP 4 = 14,048 % of Pop	TARGET POP 4 # of Clients	TARGET POP 4 "Unit" Need	TARGET POP 4 Total Revenue
RISK REDUCTION SERVICES																				
Family/Child Programs	Program	$482,618	NA	$482,618	NA	NA	0.25	$120,655	NA	NA	0.25	$120,655	NA	NA	0.25	$120,655	NA	NA	0.25	$120,655
Public MH Education/Referral	Program	$269,731	NA	$269,731	NA	NA	0.25	$67,433	NA	NA	0.25	$67,433	NA	NA	0.25	$67,433	NA	NA	0.25	$67,433
WELLNESS/REHABILITATION SERVICES																				
Information/Triage Telephone #	Program	$244,672	NA	$244,672	NA	NA	0.25	$61,168	NA	NA	0.25	$61,168	NA	NA	0.25	$61,168	NA	NA	0.25	$61,168
Community Assessment Program (CAP)	Program	$451,580	1,070	$451,580	42%	395	0.37	$166,758	50%	145	0.14	$61,385	53%	529	0.49	$223,437	0%	0	0	$0
CCLP (short-term eval/triage)	# clients	$352	400	$140,800	2%	75	75	$26,400	5%	75	75	$26,400	5%	225	225	$79,200	0.2%	25	25	$8,800
CSPs																				
Cert Ind Liv & Sup Apt	# clients	$4,505	4,178	$18,821,890	80%	3,503	3,503	$15,781,015	60%	675	675	$3,040,875	0%	0	0	$0	0%	0	0	$0
Non-Cer Ind Liv & Sup Apt (excludes WCS CSP)	# clients	$0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0
Targeted Case Management	staff	$43,000	4,942	$4,257,000	14%	670	13	$559,000	36%	525	11	$473,000	75%	3,747	75	$3,225,000	0%	0	0	$0
Geropsych Outpt and Triage Prgm	# clients	$705	1,252	$882,660	5%	233	234	$164,970	5%	71	71	$50,055	5%	245	245	$172,725	5%	702	702	$494,910
COP (Admin Staff)	Admin staff	$139,325	0	$139,325	NA	NA	0.34	$47,371	NA	NA	0.33	$45,977	NA	NA	0.33	$45,977	0%	0	0	$0
Benefits Coordination	staff	$90,000	2,801	$90,000	30%	1,426	0.3	$27,000	60%	875	0.60	$54,000	10%	500	0.1	$9,000	0%	0	0	$0
Flexible Resource Pool	# clients	$300	1,346	$403,800	20%	951	951	$285,300	10%	145	145	$43,500	5%	250	250	$75,000	0%	0	0	$0
Housing/Residential Treatment																				
CBRF	# clients	$22,214	172	$3,820,808	4%	172	172	$3,820,808	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0
Adult Family Care Home	# clients	$0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0
Health Care																				
Home Health Care	# clients	$624	192	$119,808	1%	48	48	$29,952	2%	24	24	$14,976	2%	120	120	$74,880	0%	0	0	$0
Day Activities																				
Work Programs	# clients	$3,171	560	$1,775,760	5%	237	237	$751,527	5%	73	73	$231,483	5%	250	250	$792,750	0%	0	0	$0
Community Employment	# clients	$3,184	810	$2,579,040	5%	238	238	$757,792	5%	72	72	$229,248	10%	500	500	$1,592,000	0%	0	0	$0
Psychosocial Rehabilitation Prgms	# clients	$1,436	2,333	$3,350,188	25%	1,188	1,188	$1,705,968	10%	146	146	$209,656	20%	999	999	$1,434,564	0%	0	0	$0
Day Treatment	# clients	$4,320	606	$2,617,920	5%	238	238	$1,028,160	15%	218	218	$941,760	3%	150	150	$648,000	0%	0	0	$0
Consumer Support/Educ/Adv																				
Primary Consumers	Funding	$100,000	NA	$0	(in DHS Admin)				(in DHS Admin)				(in DHS Admin)				(in DHS Admin)			
Families	Funding	$60,000	NA	$80,000	NA	NA	0.25	$20,000	NA	NA	0.25	$20,000	NA	NA	0.25	$20,000	NA	NA	0.25	$20,000
Income Management																				
Protect Payeeships	# clients	$1,694	100	$169,400	2%	80	80	$135,520	1%	20	20	$33,880	0%	0	0	$0	0%	0	0	$0
Guardianships	# clients	$0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0
Outpatient Services	# clients	$965	4,822	$4,653,230	5%	238	238	$229,332	5%	73	73	$70,397	20%	999	999	$964,421	25%	3,512	3,512	$3,389,080
Alternative Counseling	Program	$158,410	500	$158,410	0%	0	0	$0	0%	0	0	$0	0%	0	0	$0	4%	500	500	$158,410
PRE-CRISIS SERVICES																				
Assist Team	Team	$202,578	1,121	$202,578	10%	475	0.42	$85,908	10%	146	0.13	$26,371	10%	500	0.45	$90,300	0%	0	0	$0
Warmline	Warmline	$85,000	2,242	$85,000	20%	951	0.42	$36,046	20%	292	0.13	$11,065	20%	999	0.45	$37,889	0%	0	0	$0
Respite Apt/House	Apt	$180,838	160	$180,838	2%	95	0.60	$107,703	1%	15	0.09	$16,530	1%	50	0.31	$56,605	0%	0	0	$0
In-home Childcare Respite	Staff	$70,000	112	$70,000	1%	48	0.42	$29,685	1%	15	0.13	$9,112	1%	50	0.45	$31,203	0%	0	0	$0
Homeless Services																				
Mobile Community Clinic	Team	$300,000	361	$300,000	5%	238	0.66	$197,734	5%	73	0.20	$60,697	1%	50	0.14	$41,569	0%	0	0	$0
Homeless Health Care	Program	$268,297	470	$268,297	7%	333	0.71	$189,841	6%	88	0.19	$49,949	1%	50	0.11	$28,507	0%	0	0	$0
Jail/Forensic Services																				
Non-Certified: CSP	# clients	$3,452	500	$1,726,000	6%	300	300	$1,035,600	14%	200	200	$690,400	0%	0	0	$0	0%	0	0	$0
Jail Diversion	# clients	$15	1,200	$18,000	9%	450	450	$6,750	34%	500	500	$7,500	5%	250	250	$3,750	0%	0	0	$0
Eval/Tx: Hse of Correction	# clients	$455	240	$109,180	2%	100	100	$45,492	7%	100	100	$45,492	1%	40	40	$18,197	0%	0	0	$0
Forensic Outpatient Evaluation Program	# clients	$639	695	$444,077	8%	400	400	$255,583	14%	200	200	$127,792	2%	95	95	$60,701	0%	0	0	$0
Dual Diagnosis (MI/SA) Services	# clients	$444	1,450	$643,800	8%	400	400	$177,600	17%	250	250	$111,000	5%	250	250	$111,000	4%	550	550	$244,200
CRISIS RSPNSE/STABILIZATION SERVICES																				
Mobile Crisis Team	1 Team	$824,723	871	$824,723	10%	475	0.55	$450,047	10%	146	0.17	$138,148	5%	250	0.29	$236,528	0%	0	0	$0
Mental Health Police Liaison	Staff	$244,672	871	$244,672	10%	475	0.55	$133,516	10%	146	0.17	$40,985	5%	250	0.29	$70,171	0%	0	0	$0
Hotline/Crisis Line	Hotline	$244,672	2,034	$244,672	20%	951	0.47	$114,360	40%	584	0.29	$70,209	10%	500	0.25	$60,103	5%	0	0	$0
Crisis Specialists	Program	$347,276	1,888	$347,276	20%	951	0.50	$174,861	30%	438	0.23	$80,514	10%	500	0.26	$91,901	0%	0	0	$0
Crisis Respite Beds/Apt/House	Apt	$180,838	357	$180,838	4%	190	0.53	$96,359	8%	117	0.33	$59,158	1%	50	0.14	$25,321	0%	0	0	$0
Psychiatric Crisis Service	# clients	$514	2,499	$1,284,486	15%	713	713	$366,482	40%	584	584	$300,176	10%	500	500	$257,000	5%	702	702	$360,828
TOTAL COMMUNITY-BASED SERVICES				**$52,683,077**				**$29,289,695**				**$7,640,946**				**$10,826,953**				**$4,925,483**
REVENUE ALLOCATION PER PERSON				$2,086				$6,162				$5,237				$2,167				$351

Table 12

REVENUE DISTRIBUTION FOR PROPOSED SERVICE SYSTEM

SERVICE COMPONENT	CURRENT TOTAL REVENUE	UNIT	# UNITS	UNIT COST	TOTAL COST	REVENUE TOTAL	CSP/ STATE	MHBG	COMM AIDS	TAX	ORENSIC	IMD	FED PATH	GPVT PURCH	T-18	T-18/ T-19	FED T-19	FED/ STA T-19	FED/ LOC T-19	MCH/CFP	COP	SELF PAY	MISC
RISK REDUCTION PROGRAMS																							
Family/Child Programs	$164,914	PRGM	1	$482,618	$482,618	$482,618			$65,871	$254,417													162,330
Public MH Education/Referral	103,462	PRGM	1	269,731	269,731	$269,731			39,131	123,044													107,556
RISK REDUCTION SUBTOTAL	$268,376		2		$752,349	$752,349	0	0	105,002	377,461	0	0	0	0	0	0	0	0	0	0	0	0	269,886
WELLNESS/REHABILITATION SERVICES																							
Information/Triage Telephone	0	PRGM	1	$244,672	$244,672	$244,672				244,672													
Community Assessment Progra	0	PRGM	1	451,580	451,580	451,580				451,580													
CCLP (short-term eval/triage)	140,006	CLIENT	400	352	140,800	140,800			140,000	800													
CSPs																							
Cert Ind Liv	2,843,712	CLIENT	4,178	4,505	18,821,890	18,821,890	500,627	67,294	2,991,361	1,748,464		3,031,649			1,924,422	203,375	7,520,400		268,752	15	516,186	8,831	40,514
Non-Cer Ind Liv (exc WCS)	104,390	CLIENT	0	0	0	0			0													0	0
Sup Apt CSP: Certified	87,134	CLIENT	0	0	0	0			0														
Sup Apt CSP: Non-Certified	414,603	CLIENT	0	0	0	0			0													0	0
Targeted Case Management	0	STAFF	99	43,000	4,257,000	4,257,000						2,808,476					1,448,524						
Geropsych Triage Prgm	734,900	CLIENT	1,252	705	882,660	882,660			609,758	65,149					57,818	115,534		7,639		2,031		2,421	22,310
COP (Admin Staff)	139,325	STAFF	0	139,325	139,325	139,325			39,611												99,714		
Benefits Coordination (Hsng F-	0	PRGM	2	90,000	90,000	90,000				90,000													
Flexible Resource Pool	0	CLIENT	1,346	300	403,800	403,800			393,800	10,000													
Housing/Residential Treatment																							
CBRF	5,442,451	CLIENT	172	22,214	3,820,808	3,820,808			1,716,127			472,718		496,752				206,140			234,647	674,426	19,998
Adult Family Care Home	185,886	CLIENT	0	0	0	0			0													0	
Health Care																							
Home Health Care	0	CLIENT	192	624	119,808	119,808			119,808														
Day Activities																							
Work Programs	554,905	CLIENT	560	3,171	1,775,760	1,775,760			1,703,339														
Community Employment	315,244	CLIENT	810	3,184	2,579,040	2,579,040			2,530,943												425		71,996
Psychosocial Clubs	280,065	CLIENT	2,333	1,436	3,350,188	3,350,188			2,445,881														48,097
Day Treatment	4,056,867	CLIENT	606	4,320	2,617,920	2,617,920			1,061,636						140,699	212,095		966,605		127,100	26,910	85,149	819,158
Consumer Support/Educ/Adv																						19,858	63,017
Primary Consumers	0	STAFF	0	100,000	0	0																	
Families	29,720	PRGM	1	80,000	80,000	80,000			29,720	50,280													
Income Management																							
Protect Payeeships (Com Adv)	42,353	CLIENT	100	1,694	169,400	169,400			56,768														
Guardianships	22,800	CLIENT	0	0	0	0			0									47,997					64,635
Outpatient Counseling/Medicat	9,069,108	CLIENT	4,822	965	4,653,230	4,653,230			1,851,790						150,874	304,798		979,774		624,822		291,101	450,071
(incl Homeless Mob Com Clin)																							
Alternative Counseling	158,410	PRGM	1	158,410	158,410	158,410			44,261													5,905	108,244
WELLNESS SUBTOTAL	$24,621,879				$44,756,291	$44,756,291	500,627	67,294	15,734,803	2,660,945	0	6,312,843	0	496,752	2,273,813	835,802	8,968,924	2,208,155	268,752	753,968	877,882	1,087,691	1,708,040
PRE-CRISIS SERVICES																							
Assist Team	0	TEAM	1	202,578	202,578	202,578			202,578														
Warmline	0	PRGM	1	85,000	85,000	85,000			85,000														
Respite Apt/House	0	APT.	1	180,838	180,838	180,838			180,838														
In-home Childcare Respite	0	PRGM	1	70,000	70,000	70,000			70,000														
Homeless Services																							
Mobile Community Clinic	0	TEAM	1	300,000	300,000	300,000			300,000														
Homeless Health Care	268,297	PRGM	1	268,297	268,297	268,297							181,015	45,925									41,357
Jail/Forensic Services																							
Non-Certified: CSP	786,978	CLIENT	500	3,452	1,726,000	1,726,000			1,139,962		182,464								188,481		43,824		171,269
Jail Diversion	15,274	CLIENT	1,200	15	18,000	18,000			18,000														
Eval/Tx: House of Corrections	109180	CLIENT	240	455	109,180	109,180			109,180														
Forensic Outpatient Evaluation I	444,078	CLIENT	695	639	444,077	444,077			444,077														
Dual Diagnosis Services (MI/SA	322,847	CLIENT	1,450	444	643,800	643,800			558,140						11,271	22,302		29,260		19,048			3,779
PRE-CRISIS SUBTOTAL	$1,946,654				$4,047,770	$4,047,770	0	0	3,107,775	0	182,464	0	181,015	45,925	11,271	22,302	0	29,260	188,481	19,048	43,824	0	216,405
CRISIS RSPNSE/STABILIZATION SERVICES																							
Mobile Crisis Team	0	TEAM	1	824,723	824,723	824,723			824,723														
Mental Health Police Liaison	0	STAFF	1	244,672	244,672	244,672			244,672														
Hotline/Crisis Line	0	PRGM	1	244,672	244,672	244,672			244,672														
Crisis Specialists	0	PRGM	1	347,276	347,276	347,276			347,276														
Crisis Respite Beds/Apt/House	0	PRGM	1	180,838	180,838	180,838						180,838											
Psychiatric Crisis Service (PCS)	4,477,318	CLIENT	2,499	514	1,284,486	1,284,486			942,550						30,294	72,891		30,967		107,448	0	1,196	99,140
CRISIS RESPS/STABIL SUBTO	$4,477,318				$3,126,667	$3,126,667	0	0	2,603,893	0	0	180,838	0	0	30,294	72,891	0	30,967	0	107,448	0	1,196	99,140
TOTAL COMMUNITY REVENI	$31,314,227				$52,683,077	$52,683,077	500,627	67,294	21,551,473	3,038,406	182,464	6,493,681	181,015	542,677	2,315,378	930,995	8,968,924	2,268,382	457,233	880,464	921,706	1,088,887	2,293,471
INPATIENT SERVICES	$44,569,696	BEDS	245	$95,089	$23,296,733	$23,296,733			474,757	6,537,248		1,048,405			3,177,163	876,933		1,955,826		4,082,934		49,576	5,093,889
TOTAL REVENUES	$75,883,923				$75,979,810	$75,979,810	500,627	67,294	22,026,230	9,575,654	182,464	7,542,086	181,015	542,677	5,492,541	1,807,928	8,968,924	4,224,208	457,233	4,963,398	921,706	1,138,463	7,387,360

Table 13

COMPARISON OF FY92 AND PROPOSED REVENUE DISTRIBUTION BY SERVICE CATEGORY

SERVICE CATEGORY	FY 92 AMOUNT	FY 92 % OF TOTAL DIRECT SVC REVENUE	PROPOSED AMOUNT	PROPOSED % OF TOTAL DIRECT SVC REVENUE
RISK REDUCTION	$268,376	0.3%	$752,349	1%
WELLNESS/REHABILITATION	$24,621,879	31%	$44,756,291	59%
PRE-CRISIS	$1,946,654	2%	$4,047,770	5%
CRISIS RESPONSE/STABILIZATION	$4,477,318	6%	$3,126,667	4%
INPATIENT	$49,196,836	61%	$23,296,733	31%
NEW ADMINISTRATIVE COSTS **	0		$2,092,355	
TOTAL	$80,511,063		$78,072,165	

** New Administrative Costs include:

$338,390	DHS Reorganization (New Staff)
$398,900	DHS Reorganization (Consumer Activities, HRD Activities, Service Evaluation)
$513,992	MIS On-Going Maintenance
$841,073	Outstanding County Crosscharges needed by Adult Mental Health system, but not allocated to specific service components
$2,092,355	

Table 14

COMPARISON OF FY92 AND PROPOSED REVENUE DISTRIBUTION BY SERVICE COMPONENTS

SERVICE COMPONENT	FY92 REVENUE	% of TOTAL REVENUE	PROPOSED REVENUE	% of TOTAL REVENUE
RISK REDUCTION PROGRAMS				
Family/Child Programs	$164,914	0.20%	$482,618	0.64%
Public MH Education/Referral	103,462	0.13%	269,731	0.36%
RISK REDUCTION SUBTOTAL:	**$268,376**	0.33%	**$752,349**	0.99%
WELLNESS/REHABILITATION SERVICES				
Information/Triage Telephone	0	0.0%	$244,672	0.3%
Community Assessment Program	0	0.0%	451,580	0.6%
CCLP (short-term eval/triage)	140,006	0.2%	140,800	0.2%
CSPs				
Cert Ind Liv	2,843,712	3.5%	18,821,890	24.8%
Non-Cer Ind Liv (exc WCS)	104,390	0.1%	0	0.0%
Sup Apt CSP: Certified	87,134	0.1%	0	0.0%
Sup Apt CSP: Non-Certified	414,603	0.5%	0	0.0%
Targeted Case Management	0	0.0%	4,257,000	5.6%
Geropsych Triage Prgm	734,900	0.9%	882,660	1.2%
COP (Admin Staff)	139,325	0.2%	139,325	0.2%
Benefits Coordination (Hsng F-A)	0	0.0%	90,000	0.1%
Flexible Resource Pool	0	0.0%	403,800	0.5%
Housing/Residential Treatment				
CBRF	5,442,451	6.8%	3,820,808	5.0%
Adult Family Care Home	185,886	0.2%	0	0.0%
Home Health Care	0	0.0%	119,808	0.2%
Day Activities				
Work Programs	554,905	0.7%	1,775,760	2.3%
Community Employment	315,244	0.4%	2,579,040	3.4%
Psychosocial Clubs	280,065	0.3%	3,350,188	4.4%
Day Treatment	4,056,867	5.0%	2,617,920	3.4%
Consumer Support/Educ/Adv				
Primary Consumers	0	0.00%	In DHS	0.00%
Families	29,720	0.04%	80,000	0.11%
Income Management				
Protect Payeeships (Com Adv)	42,353	0.1%	169,400	0.2%
Guardianships	22,800	0.0%	0	0.0%
Outpatient Counseling/Medication Assistance (incl Homeless Mob Com Clin)	9,069,108	11.3%	4,653,230	6.1%
Alternative Counseling	158,410	0.2%	158,410	0.2%
WELLNESS SUBTOTAL	**$24,621,879**	30.6%	**$44,756,291**	58.9%
PRE-CRISIS SERVICES				
Assist Team	0	0.0%	202,578	0.3%
Warmline	0	0.0%	85,000	0.1%
Respite Apt/House	0	0.0%	180,838	0.2%
In-home Childcare Respite	0	0.0%	70,000	0.1%
Homeless Services				
Mobile Community Clinic	0	0.0%	300,000	0.4%
Health Care	268,297	0.3%	268,297	0.4%
Jail/Forensic Services				
Non-Certified: CSP	786,978	1.0%	1,726,000	2.3%
Jail Diversion	15,274	0.0%	18,000	0.0%
Eval/Tx: House of Corrections	109180	0.1%	109,180	0.1%
Forensic Outpatient Evaluation Center	444,078	0.6%	444,077	0.6%
Dual Diagnosis Services (MI/SA)	322,847	0.4%	643,800	0.8%
PRE-CRISIS SUBTOTAL	**$1,946,654**	2.4%	**$4,047,770**	5.3%
CRISIS RSPNSE/STABILIZATION SERVICES				
Mobile Crisis Team	0	0.0%	824,723	1.1%
Mental Health Police Liaison	0	0.0%	244,672	0.3%
Hotline/Crisis Line	0	0.0%	244,672	0.3%
Crisis Specialists	0	0.0%	347,276	0.5%
Crisis Respite Beds/Apt/House	0	0.0%	180,838	0.2%
Psychiatric Crisis Service (PCS)	4,477,318	5.6%	1,284,486	1.7%
CRISIS RESPS/STABIL SUBTOTAL	**$4,477,318**	5.6%	**$3,126,667**	4.1%
TOTAL COMMUNITY REVENUES	**$31,314,227**	38.9%	**$52,683,077**	69.3%
INPATIENT SERVICES	**$49,196,836**	61.1%	**$23,296,733**	30.7%
TOTAL REVENUES	**$80,511,063**		**$75,979,810**	

Table 15

COMPARISON OF UTILIZATION OF REVENUES BY REVENUE SOURCE

REVENUE SOURCE	FY92		PROPOSED	
	% OF TOTAL ADULT MH SYSTEM REVENUE	% USED PRIMARY SERVICE AREA	% OF TOTAL ADULT MH SYSTEM DIRECT SVC REVENUE	% USED PRIMARY SERVICE AREA
COMMUNITY AIDS	27%	WELLNESS/REHAB (76%)	29% *	WELLNESS/REHAB (71%)
TAX LEVY	12%	INPATIENT (96%)	13% **	INPATIENT (68%)
MEDICAID/MEDICARE	25%	INPATIENT (66%)	28%	WELLNESS/REHAB (69%)
HEALTH CARE FINANCING PRGM	11%	INPATIENT (90%)	7%	INPATIENT (82%)
IMD	9%	INPATIENT (94%)	10%	WELLNESS/REHAB (84%)
OTHER	16%	INPATIENT (52%)	14%	INPATIENT (57%)

* Increased percentage due to decrease in total system revenue; revenue amount stays constant.
** Increased precentage due to decrease in total system revenue and addition of Lawsuit Settlement allocation

OTHER FISCAL ISSUES

There are several broader fiscal issues which also need to be addressed within Milwaukee County and within the State of Wisconsin.

MEDICAID COVERAGE

Lack of creative Medicaid coverage for pre-crisis and crisis services is a problem throughout the state of Wisconsin. Although all of the services recommended in this Plan can be implemented under the existing Medicaid funding regulations, the Wisconsin mental health service system is missing an opportunity to access more federal revenues to facilitate implementation of services such as those contained in the Milwaukee County Mental Health Plan. The State Plan covers only certain on-site clinic services on a fairly restrictive basis. There could be much more comprehensive coverage (including mobile capacity) of assessment and crisis intervention/stabilization services in order to enable programs that promote these services to become more financially viable.

Milwaukee County and other local mental health authorities should work together with the State Mental Health and Medicaid agencies to consider strategies to expand coverage for these and other important services. Traditionally, such strategies would include state plan amendments for these services, and possibly mechanisms to use already allocated state and local funds or FFP match, as is done for CSP and Targeted Case Management Services. The current era, however, does not call for traditional strategies and solutions. National Health Care Reform will almost certainly result in a capping of Medicaid and the adoption of managed care methods to constrain a growth in costs. A number of states (Tennessee and others) are beginning now to implement broad-based waiver programs at an early enough point to allow the state to shape its own managed care strategies before possibly home restrictive and financially less favorable methods are put in place. The Health Care Financing Administration has recently demonstrated a much greater willingness, than in the past, to work with states on demonstration and other types of waivers that permit greater flexibility in service coverage in exchange for limitations in growth of federal outlays for services. If Milwaukee County and the rest of Wisconsin's mental health system consider that service coverage needs to be more flexible and comprehensive, it may be best to work with the State Medicaid Agency and other segments of Wisconsin's health care system as part of a broader-based health care reform initiative.

CAPITATION AND MANAGED CARE

As noted above, National Health Care Reform will most likely result in a major focus on managed care approaches for containing health care costs, including those within the mental health service delivery system. In the context of public mental health, a managed care

system is primarily one where all resources related to mental health care are managed by a single entity that then provides or contracts out for services to individuals eligible for the service. This approach emphasizes promoting less costly preventative services to reduce overall costs for the managed care provider, as opposed to the traditional fee-for service approach which has dominated the medical and related human service professions in our country.

The recommendations in this plan for developing a single point of authority with a unified budget, use of a competitive bidding process and performance contracting for all services, and implementation of an integrated management information system position the County of Milwaukee to respond favorably to the new emphasis on managed care. In addition, in a managed care environment, access/point of entry screening, assessment, crisis, and diversion service capacities are essential. As such, the recommendations for Milwaukee County to have these capacities in place will enable the system to function effectively in a managed care environment.

The combination of having clear target population definitions, using a RFP process for all services, and performance contracting with all providers could allow the Division to develop a capitation initiative for people with the most severe needs. In capitation systems, all funds are consolidated in one pool and a predetermined amount is allocated to providers who contract to meet all the needs and achieve desired outcomes for specific groups of individuals (i.e., long stay inpatient residents). In capitated systems, the provider is responsible for effective utilization of the allocated resources across all individuals for all services needed by each person (including community and inpatient services), thus encouraging more proactive service provision to prevent the need for more intensive, costly reactive services. In essence, it is a managed care approach to serving people with the most intensive needs, but one that focuses on consumer outcomes rather than on funding source requirements. Performance contracts, MIS data, and service evaluation activities are used to assure that individual quality of care is enhanced rather than compromised through the capitation process.

Capitation initiatives also encourage high quality inpatient services, in that there is a strong incentive for good communication regarding admission, treatment and discharge planning between the community and inpatient staff assisting the individual consumer. There also is strong incentive for inpatient programs to refine their services based on the specific needs of the people who require specialized clinical services or treatment, and thus, reinforces the notion that inpatient services must also be held accountable for consumer outcomes, rather than be seen as the "holding tank" for people no one wants, or has the resources, to serve.

The Department of Human Services should also begin to examine the relationship between the public and private sector mental health service systems. Within the context of Milwaukee County, this new emphasis on managed care could take effect in several ways. For example, one or more of the general hospitals providing mental health services could join into a single managed care entity, with Milwaukee County citizens paying a monthly fee

for all medical services, including psychiatric services, and these hospitals also pooling their revenues received for serving Medicaid and Medicare eligible persons (these reimbursement mechanisms are projected to remain intact for persons with mental illness, although they most probably will be capped). On the other hand, the Adult Mental Health Division could begin negotiations with the state Medicaid/Medicare Authority to capture and manage all Medicaid/Medicare revenues for psychiatric care coming into the County. The Division would then be in the position to use these and all other revenues to contract for, and control the quality of, most of the services provided to people with mental illness in the county through a capitated financing approach. In order to implement this approach, which is currently being used in several other Wisconsin counties, the county would need to incorporate incentives for agencies or general hospitals to continue to expand programming for persons who are Medicaid/Medicare eligible. In addition, the County Board of Supervisors would need to agree to a Maintenance of Effort rule, which would guarantee that this Medicaid/Medicare revenue could not be used to replace county dollars allocated for services; that is, if these federal/state dollars are reallocated to pay for different services, the services that these funds are currently supporting would be eliminated, which would be detrimental to the system as a whole. This should not be seen as a mechanism to decrease county share, but a way to increase the coordination and quality of public sector adult mental health services for Milwaukee citizens.

REIMBURSEMENT FOR CLOZARIL

In the past three years, a new medication, Clozaril, has been found to be effective in nearly one-third of patients with long-term schizophrenia who were previously unresponsive to all treatments (National Advisory Mental Health Council, 1993). However, it is very expensive and it has side effects that require close monitoring.

There are few funds available to provide reimbursement for this very expensive, but potentially extremely cost effective, medication. In recognition of this, the State of Wisconsin has developed a special appropriation for Clozaril for patients at the two State Institutions. This funding is not available to individuals at the Milwaukee County Mental Hospital, however. Therefore, the State Bureau of Mental Health and the Milwaukee County Department of Human Service should begin immediately to explore mechanisms to allow MHC patients to receive the special appropriation for Clozaril that is available to state institute patients.

SUMMARY

This Master Plan should be used as a vehicle to begin a budgeting process linked to long-range planning. This requires that multi-year budgets be developed, based on existing and future service needs, and anchored by MIS data. In order to assure adequate revenue allocation, this multi-year budgeting process must be established in a collaborative process with the Department of Administration and the County Executive.

In addition, it is crucial that DHS secure County Board support to retain within the mental health system any county-controlled revenues that might result from downsizing inpatient services, so that they may be used to develop the community-based services outlined in this plan.

ISSUES NEEDING FURTHER EXPLORATION

In addition to the fiscal issues discussed in the preceding Chapter, several other issues which need further exploration have been identified throughout this document. These are issues which were not able to be fully explored in detail within this planning process, but ones that directly impact on the lives of persons with mental illness in Milwaukee County, and on the services that they receive. As such, they are highlighted here to reinforce the importance of attending to them within the immediate future.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

It is strongly suggested that a similar planning effort begin immediately to examine the public sector mental health system for children and youth in Milwaukee County. Although they often function as two separate systems, they interface very directly in a number of ways. One obvious interface is the service provision to both populations by the Mental Health Complex. In addition, many of the individuals who receive mental health services as children and youth will transition to the adult mental health service system to continue receiving services; therefore, these two systems often serve the same people at different points in their life. One implication of this is that the values on which service are based must be consistent for the two systems, and services should be designed which reflect these shared values and service approaches. In addition, a more proactive, successful intervention at an early age should result in less need for intensive adult services later in life, which would have both humanitarian and financial rewards for the citizens of Milwaukee County.

SERVICES FOR PERSONS WITH SUBSTANCE ABUSE

People with mental illness and concomitant substance abuse problems are becoming a primary focus for many mental health systems around the country, and there is an acknowledged need for attention to this matter in Milwaukee County.

In FY92, MHC operated a program which provided outpatient services to 727 individuals who abused alcohol, as well as drug-free individuals who were addicted to drugs, but who, with counseling, were judged able to maintain themselves without drugs. This program, which focuses on maintaining abstinence, social readjustment, and vocational rehabilitation, was originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, it has developed into a program which mainly serves persons with a primary disorder of substance abuse, due to the lack of services within the County for these individuals. In FY92, this program served, on average, 19 people per working day.

In FY92, MHC also operated 55 inpatient beds staffed to provide treatment focused on polydrug use by adults. Similar to the Substance Abuse Counseling services offered by MHC, these inpatient beds were originally intended to serve people with a primary disorder of mental illness, with a concomitant substance abuse problem; however, these beds are mainly used to serve persons with a primary disorder of substance abuse, again due to the lack of services within the County for these individuals. These units served 617 individuals in FY92, with an average length of stay of 16.3 days.

It is strongly recommended that the resources for these dual diagnosis outpatient and inpatient services be focused to specifically address the needs of people who have both mental illness and substance abuse issues. In addition, one or more specialized CSPs should be developed to assist persons with this dual disorder, and training on this issue should be made available for all staff. It also is recommended that a joint Task Force should be convened by the Adult Mental Health Division and the Alcohol and Drug Abuse Bureau to make specific recommendations about other service needs of these individuals, such as pilot projects using multi-disciplinary teaming across programs.

The Alcohol and Drug Abuse Bureau should be responsible for developing services for persons whose primary issue is substance abuse. It is the responsibility of Director of DHS to ensure that adequate services are available to address the needs of persons with mental illness, persons with substance abuse issues, and persons with both of these disorders, and to ensure that services and funding for any one of these populations does not become subsumed by the unmet needs of any of the other two.

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

As of FY94, the Mental Health Complex (MHC) will have six rehabilitation inpatient units to serve persons with a primary diagnosis of developmental disability. In addition, persons with developmental disabilities who have concomitant psychiatric disorders or severe behavioral problems are often served within the adult acute units for persons with mental illness. As a result of a FY93 Lawsuit settlement, a number of policies for placements of persons in these latter units will be implemented, as well as new diversion services and increased living arrangements and support services to decrease the need for acute admissions by this population.

The recommendations for DHS reorganization do not directly address the organizational issues involved with the fact that MHC provides these inpatient services for persons with developmental disabilities. It is suggested that the Developmental Disabilities Bureau of the Department of Human Services develop a contractual agreement with MHC for the provision of these services. It is also recommended that very careful screening procedures be put in place in the MHC acute units to ensure that persons with developmental disabilities are not inappropriately admitted for acute inpatient care as a result of behavioral, rather than mental illness, problems. In order to provide high quality, effective

care, the acute inpatient services must be allowed to focus on serving the acute needs of persons with a primary diagnosis of mental illness, as well as those with a differential secondary diagnosis, and not continue to be used as a back-up placement for any person who other services and/or service systems reject.

HUMAN RESOURCE DEVELOPMENT NEEDS

A number of issues and strategies for addressing the workforce needs within the Milwaukee County mental health system have been identified in Chapter Five of this Master Plan. Often in systems change initiatives, however, these issues are overlooked in the enthusiasm to move forward on service development or structural re-organization. Although focusing on achieving positive consumer outcomes should always take priority over other concerns, such as maintaining existing programs or jobs, staff are the "bricks and mortar" of high quality, responsive mental health service delivery systems. Unfortunately, most mental health systems, including Milwaukee County, focus little attention or resources on maintaining or enhancing this vital element of service effectiveness. As such, it is extremely difficult to recruit and retain a workforce that is adequately skilled, culturally relevant, and dedicated to helping people with mental illness achieve their desired outcomes.

Implementation of a comprehensive, responsive mental health system, such as the one described in this Master Plan, cannot be successful without a strong focus on the human resource development needs within the system. New staff will need to be recruited and trained (Recruitment and Pre-service Training) and existing staff will need to learn new skills and be given opportunity for advancement (In-service Training and Redeployment Opportunities). As such, it is recommended that the proposed Division of Adult Mental Health have 1.0 FTE staff to specifically focus on human resource development needs, with an annualized budget of $250,000 for staff training and development. This position mst be in place as soon as possible, in that staff training must occur prior to any new service development.

CONSUMER INVOLVEMENT

People with direct experiences in the mental health/illness system (as either ex-patients or active service recipients) and their family members have unique contributions to make toward improving the quality and function of the mental health system. They are the most knowledgeable resources for providing information about what is working well and what needs to be improved. A primary goal of the Milwaukee County mental health system should be the promotion of positive images of people with psychiatric disability through the use of appropriate non-stigmatizing language, and the provision of opportunities for making positive contributions, through governance, system feedback, and employment.

Consumers should have active and vital roles in the agencies and organizations which collectively constitute the mental health system. To realize this goal, the involvement of consumers as board members should be mandated for all mental health agencies receiving a majority of their funds through the Adult Mental Health Division, as well as for the Master Plan Advisory Committee and the Combined Community Services Board.

The mental health system should establish on-going mechanisms for obtaining information from consumers about its effectiveness in meeting the needs of its service recipients. Such mechanisms include obtaining written information, conducting regular meetings between policy-makers and consumer and family groups, and inclusion in the design and implementation of service evaluation activities.

Agencies should be encouraged to create jobs specifically for consumers. To adequately support consumer staff, procedures must be developed for assuring reasonable accommodation. Non-consumer staff also may need on-going training or other mechanisms for exploring the usefulness of, and how to provide assistance with, the integration of consumer staff into the workforce.

In order to assist with the above efforts, and to assure that consumer involvement is at the forefront of all activities of the Adult Mental Health Division, it is recommended that a Consumer Affairs Specialist be hired within the Division as soon as possible. In addition to the above activities, this staff would help consumers throughout the county develop support groups, respond to Requests for Proposals to provide consumer-operated services, and so forth. A budget of $48,900 has been allocated to the DHS reorganization costs to assist with these activities.

ETHNIC AND CULTURAL DIVERSITY AND COMPETENCE

The mental health service system in Milwaukee must attend to issues of both cultural and ethnic competence, in that this area has been neglected in the past years. As a result, there are few provider agencies which have services targeted specifically to people of color or from various ethnic or cultural backgrounds. In addition, recruitment and employment of staff who are of color must be a priority, since they are very under-represented within the workforce. This is especially true at the management level, where effective policy and service planning requires input from individuals with this perspective.

Although several strategies have been used in the past to address this issue, a VERY PROACTIVE approach must be taken to identify and promote strategies for recruitment and retention of persons from diverse cultural groups at all levels in the mental health service delivery system. In addition, the implementation of the Human Resource Development strategies discussed above must occur in order to successfully recruit and retain minority professionals within the mental health system in Milwaukee County.

The Adult Mental Health Division also needs to periodically review service patterns for people of color, including the differential nature of diagnosis, access, discharge planning and follow-up, quality of outcomes, patterns of mental health service utilization, service representation for persons of color, and utilization of the criminal justice system. Services and staff supports and training must then be developed to create more ethnic and culturally responsive services.

The mental health service delivery system also should hold accountable administrative and provider organizations for promoting cultural competence and value diversity through the contracting and evaluation mechanisms.

EVALUATION METHODS

At the heart of this plan is the assumption that all services should focus on achieving positive outcomes for the people they serve, and that funding sources and strategies are mechanisms for achieving these outcomes. Survival of programs or provider agencies should be dependent on the quality of the services they provide, measured in terms of consumer outcomes and satisfaction. The Adult Mental Health Division must begin a process to identify specific outcomes for each service component and to develop methods for assessing performance on these outcomes, as well as methods for assessing service satisfaction. Without such information, it is impossible to monitor whether the system is using its resources to effectively meet the needs of its service recipients.

Specific consumer outcome indicators will need to be developed for each individual service component, and these outcomes should reflect the changes in individuals' lives that the program is meant to accomplish. Such key consumer outcomes include increases in rates of consumer employment, at which consumers receive income support and entitlements, at which consumers achieve desired and decent housing, and at which consumers are actively engaged in natural support networks; and decreases in symptomatology, crisis service and hospital utilization rates, numbers of days spent incarcerated and/or homeless, and rate of substance abuse. These outcomes also should be aggregated across all service components by the Adult Mental Health Service Division to assess system effectiveness and identify gaps.

Satisfaction measures should focus on consumer and family opinions of service quality, including indicators of service accessibility and responsiveness; flexibility based on individual needs; respectfulness; cultural and ethnic sensitivity and relevance; emphasis on consumer choice and involvement; and other values which are contained in the Guiding Principles.

There are a variety of methods for collecting this information, including surveys, focus groups, attending family and consumer meetings, and developing consumer satisfaction teams which visit programs and speak directly with consumers and family members, and see the services first-hand.

CONCLUSION

The successful implementation of this Master Plan for the Public Sector Mental Health Service System for adults in Milwaukee County cannot occur without the full support of all constituencies, strong leadership from the Department of Human Services, and a commitment by the County Executive and County Board of Supervisors to the fiscal and programmatic directions within the plan.

The recommendations of inpatient downsizing, community service enhancement, and creation of a single point of authority must be implemented *SIMULTANEOUSLY*; to implement only one or two of these elements would drastically undermine the integrity of the plan, and would continue the current fragmented service system in which individuals cannot receive responsive and effective services to meet their needs in a proactive rather than reactive way. The projected savings to Milwaukee County are a result of creating a seamless service system that will have positive benefits for each person needing services in terms of quality of life, and that will ultimately benefit the taxpayers of Milwaukee County in terms of decreased mental health service direct cost escalation, and decreased indirect costs to society due to mortality, morbidity, adjunct social welfare services, and family caregiving expenditures associated with severe mental illness when effective services ar not available.

As with any plan, this one should not be considered as an end product, but rather as laying the foundation on which future decisions should be made. The specifics within this plan *SHOULD CHANGE* as implementation gets under way, as the service system learns what variations are most appropriate to achieve its goals. What *SHOULD NOT CHANGE*, however, is that all decisions within the County about public sector services for adults with mental illness should adhere to, and be made in the context of, the Vision, Mission and Guiding Principles for the County of Milwaukee mental health system that were conceived and adopted by the Advisory Committee during the development of this plan. These should be considered the conscience of the system, and the rights of all adults within the county who need or desire to access public sector mental health services.