

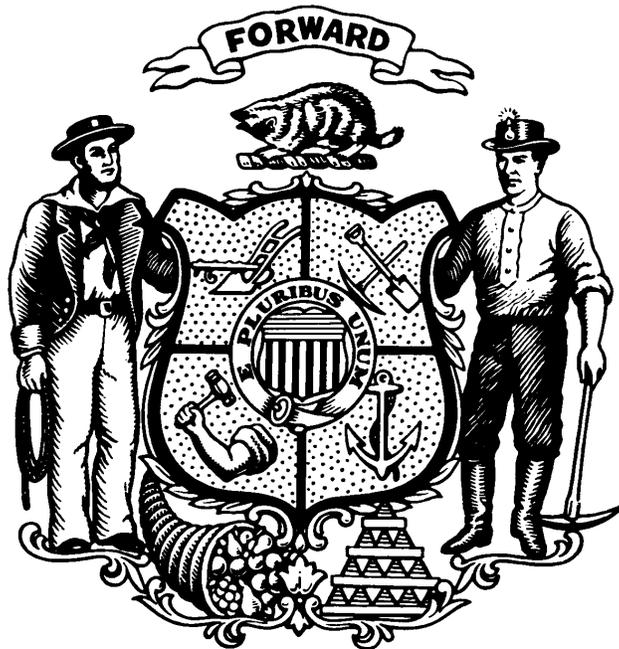
The Blue Ribbon Commission on Mental Health



FINAL REPORT



EXECUTIVE SUMMARY



SUBMITTED TO GOVERNOR
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EXECUTIVE SUMMARY

Introduction

The Governor's Blue Ribbon Commission on Mental Health was appointed in May 1996. The Governor's charge to the Commission was to examine the mental health delivery system and the principle of a state/county partnership; the mental health services provided for children, adolescents, adults, and the elderly; and the impact of stigma on community perceptions and current mental health policies.

The Executive Order creating the Commission further directed it to:

- recommend model mental health delivery systems that are effective in an environment that emphasizes managed care, client outcomes, and performance contracting;
- recommend ways the federal, state, and county governments can cooperate to gain fiscal efficiencies and greater service capacity;
- recommend a service system targeted at prevention, early intervention, treatment, recovery, and positive consumer outcomes; and
- recommend ways to reduce stigma in Wisconsin's mental health policies and programs.

Commission membership included all key Wisconsin stakeholder groups interested in mental health services for the state's citizens. Members represented public and private service providers, county and state elected officials, consumers, i.e., persons who receive mental health services, consumers and their family members, advocates, the judicial community, and insurance and hospital groups.

The Commission met monthly from June 1996 until February 1997. It created three committees and several short-term work groups to develop special reports. The Commission sought broad public input from a total of more than 700 persons.

Blue Ribbon Commission work paralleled the Department of Health and Family Services Long-Term Care Redesign Initiative. The Commission provided input to the Department and made a strong commitment to coordinate mental health services with the long-term care initiative. Both initiatives are intended to build upon the foundation of a unified approach to serving persons with various disabilities set in place by Chapter 51.

Wisconsin's Mental Health System and National Trends

Until recent decades, it was assumed that persons with severe mental disorders would not be able to get better. Hence, humane custodial care was the goal of the mental health system. Similarly, it was assumed that children and adolescents with severe emotional and behavioral disorders would have to live in protected settings until they were old enough to be served by the adult system. In Wisconsin, the institutional period reached its peak in the 1950s, when the population in state hospitals was about 2,100 and in county facilities about 12,000.

In the 1960s and 1970s, the federal government began to move persons with mental disorders from hospital settings into community programs, such as group homes, sheltered workshops, and day treatment programs, which provided less restrictive services but few opportunities for community integration. This process was known as de-institutionalization.

A critical event in Wisconsin was amendment of Chapter 51 in 1971. Legislation that year created county-level 51.42/.437 boards with responsibility to plan, fund, and oversee the provision of mental health, developmental disability, and alcohol and other drug abuse services to county residents. This legislation was innovative in two ways. It decentralized responsibility for mental health services to the county level, and it made local mental health boards responsible for funding adult inpatient services in state mental health institutes. Changes in Wisconsin's mental health commitment process some years later made counties responsible for persons committed involuntarily as well. These changes moved the adult mental health system toward community-based services.

In the late 1980s and 1990s, policy makers, researchers, advocates, consumers, and family members began to question the over-reliance on professionally developed and controlled solutions to the vexing problems of community integration and empowerment. A growing consumer and family movement and a growing demand by persons with disabilities for full community membership influenced the questions. The federal Americans with Disabilities Act, a landmark civil rights law for people with disabilities, included persons with mental disorders for the first time in all of its mandates.

Recent years have also seen a questioning of the ability of the government to address deep-rooted social problems as well as an increasing demand for accountability in the use of taxpayer funds. In this climate, poignant questions have been raised about the appropriateness of providing caring services that accept lifelong dependence on mental health services and professionals rather than developing and funding ways to promote improvement, recovery, and full integration into the community. Concurrently, calls for consumer involvement in treatment planning and implementation have increased.

Similar changes have occurred in the approach to services for children and adolescents and their families. Today's view calls for collaboration among child-serving agencies, local interagency service planning and delivery structures, and returning youth from residential and inpatient settings to their families and communities.

The Concept of Recovery

The Blue Ribbon Commission adopted the concept of recovery, that is, the successful integration of a mental disorder into a consumer's life, as the key tenet of the redesigned mental health system. The goal of attaining a productive and fulfilling life, regardless of the level of health, is a powerful vision that represents an optimal use of time and resources. The fundamental idea is to let go of what was and rebuild new dreams, that is, to accept the realities of illness while focusing on LIFE.

A recovery-oriented mental health system that focuses on rebuilding full, productive lives despite a mental disorder reaches beyond the critical issues of assuring personal safety and managing symptoms. It emulates an approach already used in the area of physical disability, where people learn to lead meaningful lives despite severe injuries, and in chronic pain management, which does not eliminate pain but teaches people how to make pain less bothersome. Such an approach is the goal in any new design of mental health services.

In a recovery-oriented system, mental health consumers rebuild meaningful lives while decreasing their dependence on the system. They participate in services that enable them to recover rather than become long-term users of the mental health system. From a therapeutic as well as an economic standpoint, this approach has great appeal.

Commission Recommendations

Vision, Mission, and Guiding Principles

The Blue Ribbon Commission developed a vision, mission, and guiding principles for a redesigned mental health system to inform and guide all its tasks. The following **vision** statement conveys a sense of hope for improvement and recovery and a commitment to services that are consumer- and family-centered and that foster self-determination and self-sufficiency.

All persons in need of mental health services across Wisconsin have equal access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity.

The Commission developed the following **Mission** statement:

The mission of the mental health system throughout Wisconsin is to achieve the vision by:

?? Creating partnerships that develop, coordinate, and provide a full range of resources that address:

Risk reduction/prevention

Wellness

Early identification and intervention, treatment and rehabilitation options

Recovery

Safe and affordable housing

Educational, employment, social, and recreational opportunities

Family and peer support

Self-help services

Safety and well-being of all members of the community

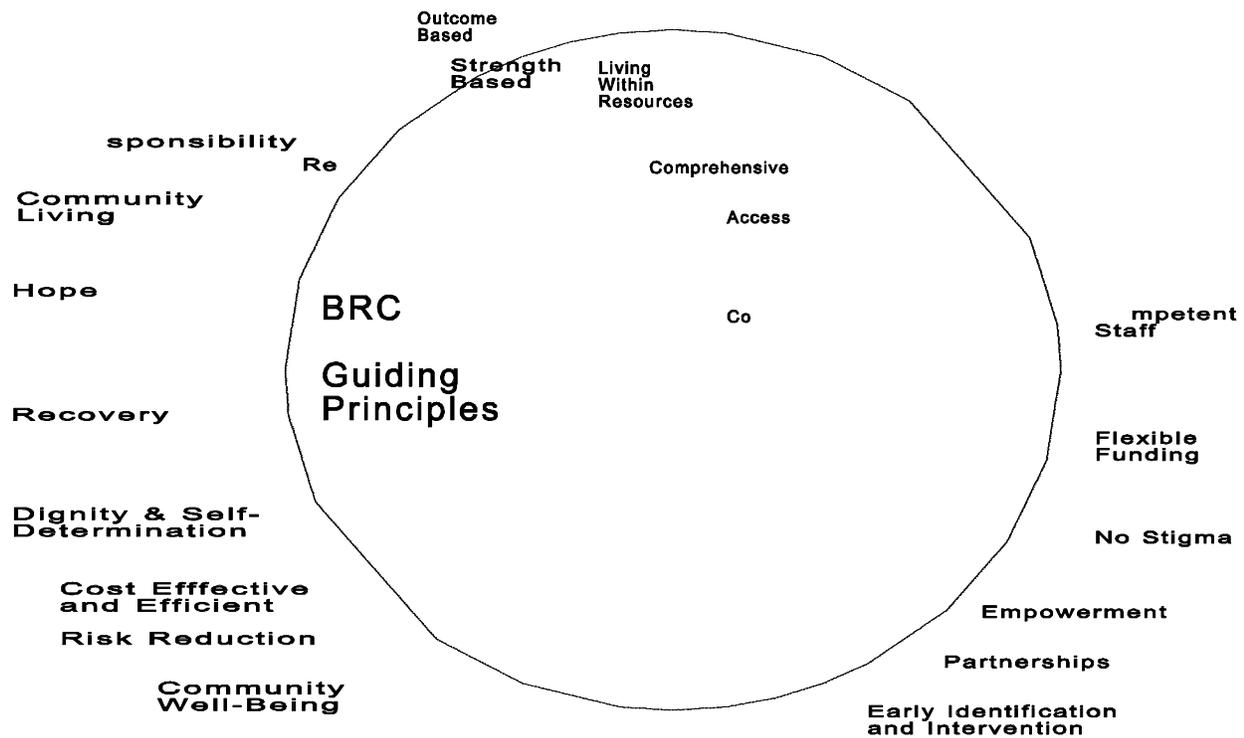
?? Emphasizing hope and optimism in all interactions

?? Implementing a comprehensive strategy to eradicate stigma and discrimination

?? Involving consumers/families/communities as equal stakeholders in all aspects of service system governance, planning, and delivery

?? Acknowledging the abundance and limitation of our human and financial resources and committing to responsible stewardship of these resources

The following **Guiding Principles** were developed to guide the Commission and the future mental health system in funding, policy, and program development. The illustration in the following page portrays the concepts followed by the Blue Ribbon Commission:



Persons To Be Served

The Commission recognized an obligation to give specific consideration to the unique needs of children, their families, and older persons as well as the needs of adults. This will require definition of specific outcomes, services, and indicators that are sensitive to the needs of persons at different life stages.

As the Commission considered its charge, it recognized a need to identify groups of individuals to be served by the mental health system. Rather than rely on diagnostic categories, that is, groupings of types of mental disorders, the Commission decided to support groupings based on the level of a person's service needs.

The Commission identified five target populations for which to plan mental health services. Three of these need treatment and recovery services and two-need prevention and early intervention services. Each group includes people of all ages.

Groups in need of treatment and recovery services

- Persons in need of ongoing, high intensity, comprehensive services
- Persons in need of ongoing, low intensity, comprehensive services
- Persons needing short-term situational services

Groups in need of prevention and early intervention services

- Persons at risk
- Persons at an acceptable level of mental health

The Commission also discussed involuntary treatment. A person can receive services involuntarily in a number of ways: civil commitment under Chapter 51, protective placement or services under Chapter 55, or as a result of involvement in the criminal justice system. The Commission recognized that court-ordered services can be a tool to provide needed services and that some people's access to services must be facilitated through involuntary commitment. The Commission expects the system to provide similar services to both voluntary and involuntary consumers.

The Commission strongly recommends that the mental health system emphasize voluntary treatment and minimize use of involuntary interventions by using a variety of treatment, support, and prevention efforts, including peer support and early detection.

Consumer Outcomes

The foundation of a successful mental health system is its ability to assist a person with a mental disorder to realize outcomes that matter to him/her. Services, performance measures, organizational structures, financing, all the features essential to the design and operation of a system, are secondary to identifying and achieving positive consumer outcomes.

The Commission recommends that consumer outcomes focus not only on clinical outcomes but also on outcomes that improve quality of life. Although outcomes are generally similar for adults, children, and older persons, specific indicators and measures may take different forms for persons at different life stages.

The Commission developed strong consensus that the redesigned mental health treatment system have measurable, useful consumer outcome performance indicators, including self-reports by consumers. In the redesigned system, consumers will be empowered to take control of their own lives and be given the opportunity to learn how to be responsible for their actions and decisions. Consumers, in partnership with mental health providers, are to be accountable for the effective use of resources.

The Commission recommends that the Department of Health and Family Services establish a work group of state staff and key stakeholders, including consumers and family members, to define specific performance indicators and tools for measuring outcomes. These should form the basis for contracts in the redesigned mental health system.

The Commission identified fifteen desired outcomes and grouped them into three categories. Those that contribute to the attainment of additional positive outcomes can be called “energizing outcomes”. Another group, “clinical outcomes”, addresses issues of health and the treatment of illness. The third group, “community living outcomes”, relates to areas of successful living.

Energizing Outcomes

Consumer satisfaction, empowerment and self-esteem access, personal safety, awareness, equal opportunity

Clinical Outcomes

Symptom relief, psychological well-being, physical health

Community Living Outcomes

Social relations and supports, meaningful activities and occupations, goal attainment, basic survival and housing, freedom from substance abuse, daily living skills

Prevention and Early Intervention Services

Mental disorders range from mild to severe. They can have acute episodes and/or be of long-term duration. Current research points to multiple causation for these disorders, ranging from biological and genetic origins to psychological, social, and cultural causative factors.

Prevention and early intervention means that many of these conditions can be reduced in absolute number, delayed in onset, or lessened in severity if specific risk factors are reduced, certain protective factors enhanced, and early warning signs treated promptly. Therefore, onset of some mental disorders may be averted completely, postponed, or ameliorated. The Blue Ribbon Commission stated that the biologically-based disorders cannot be prevented at this time, but early intervention can be instrumental in modifying their course.

The Commission recommends three diagnoses as priority targets for specific prevention and early intervention activities:

1. conduct disorder in children;
2. depression in all age groups;
3. post-traumatic stress disorder in all age groups.

Research on prevention strategies for these disorders is especially compelling and identifies specific, successful, preventive interventions that address these disorders effectively.

The Commission recommends that current scientific literature be consulted in the design and implementation of prevention strategies for the targeted disorders and populations and that only those programs with demonstrated effectiveness be replicated in Wisconsin. The full report details characteristics of effective prevention programs, resources for information on effective prevention programs, and desired outcomes for each stage of life.

The Commission recommends that a predetermined dollar amount be set aside in each contract for planned prevention activities in the priority areas. In addition, a separate “prevention in mental health” fund should be established to provide matching funds to encourage community and/or private partnership.

The Commission recognizes that mental health prevention is poorly understood and that training and technical assistance will be necessary to encourage development of a statewide system of mental health prevention services. It also recognizes that collaboration with state and non-state agencies is important in the promotion and delivery of prevention activities.

Treatment and Recovery Services

The Commission identified groups of services that should be available to help consumers achieve desired outcomes. This menu of services should be viewed as minimum, with great flexibility to provide services in a way that best meets consumers’ needs, not the needs of service providers or funding sources. The Commission recommends that a comprehensive range of services encompass not only traditional mental health (e.g. outpatient clinic and intensive in-home) and in-resident (e.g. hospital and crisis) services, but also two additional groups of services essential to both recovery and to the accomplishment of successful community living outcomes. Services identified by the Commission can be grouped into four broad categories, which will be available with variations appropriate to different age groups, which are:

1. “Core” mental health services, that is, assessment, crisis intervention, case management, etc.;
2. Self-help, peer support, and natural supports;
3. Community supportive services;
4. In-residence services.

The pattern of expected services to be offered will be influenced both by the age of the consumer and the intensity of service needs. As consumer needs become more complex, the menu of services becomes more extensive. Only four services are expected to be required for all persons. They are:

- community education;
- client identification and information and referral;
- crisis intervention and resolution; and

- comprehensive assessment and individualized service planning.

The Commission recommends that the redesigned mental health system emphasize flexibility and creativity, with the expectation that new treatment and recovery services and resources will be developed. The objective is to empower consumers, families, and mental health professionals to be creative as they seek to achieve mutually agreed upon outcomes.

To this end, the Commission further recommends that all consumers participate in comprehensive assessment; receive highly individualized services based on that assessment and the consumer's chosen way of life; have a plan of services designed to achieve positive consumer outcomes, including self-sufficiency; be served with dignity, respect, and the least restrictive interventions necessary to achieve consumer outcomes; and receive services that meet any applicable standards of care.

Addressing the Stigma of Mental Disorders

The commission identified the following problems:

- Stigma inhibits people's seeking mental health services;
- The stigma associated with poverty and minority status compounds the stigma of mental disorder;
- The mental health system itself uses stigmatizing diagnostic labels;
- People with mental disorder experience discrimination in many areas, such as employment, housing, insurance coverage;
- The media present people with mental disorder as dangerous and unpredictable;
- Some people with mental disorder feel dis-empowered and worthless, an experience sometimes called self-stigma;
- Some children with special needs experience discrimination in the school system.

The Commission concluded that the key remedy for stigma lies with education and society's ability to recognize mental disorder as analogous to other long-term health conditions, such as diabetes or high blood pressure. The Commission also identified the following strategies to combat stigma, which were to:

- Find ways to make Blue Ribbon Commission actions reduce stigma.
- Dedicate public funding and seek private funding for use in reducing stigma.
- Assist consumers in resolving issues of self-stigma; educate families and the general public to expect persons with mental disorders to live a healthy, productive life.
- Involve consumers and family members along with mental health professionals in the education effort.
- Address the problem of labeling directly.
- Address the impact of stigma by making services more accessible.
- Take action within the mental health system to reduce stigma toward persons with mental disorder and their families.

- Address stigma outside the mental health delivery system.
- Enforce current laws prohibiting discrimination in insurance policies, and pass new laws to make insurance coverage of mental disorder more equitable.

Financing and Organizational Structures

The Commission feels that the mental health system's design and financing should:

1. Merge the three major sources of funding for mental health services (State Community Aids, County Funds, and Medicaid) in order to provide comprehensive services for mental health treatment, recovery, and prevention and to assure that "money follows the consumer."
2. Integrate funding for institutional and community services in order to encourage development of community-based service alternatives.
3. Enhance incentives to encourage counties to reduce inpatient and nursing home care.
4. Maintain and build upon existing linkages between county mental health systems and other county-coordinated human and "safety net" services, including child welfare, criminal justice, adult protective services, etc.
5. Maintain and build upon local investments in community mental health: county funding, county risk bearing, citizen involvement, and natural support networks.
6. Develop improved data systems to guide decision making as changes in the mental health system are implemented. Specifically, data needs include: the per person cost of services funded by community aids, county tax funds, and Medicaid; consumer outcomes; and performance contract details.
7. Implement the redesigned mental health system in incremental steps to minimize disruptions in services to consumers. The "First, Do No Harm" principle should guide system change.
8. Change the system without allowing Medicaid to dominate the process, despite its being an essential funding source for community mental health services.

The Commission discussed at length the steps that need to be taken to achieve its goal of a redesigned mental health service delivery system. This deliberation addressed changes to be made immediately, those to be piloted, and the end product desired. The result of this process is the action plan that follows.

Action Plan

The Blue Ribbon Commission recommends several important changes in Wisconsin's county-based mental health system. These changes will develop the capacity of all partners in the system to respond successfully to the renewed vision of Wisconsin's mental health system. Through these changes, the state will increasingly measure success by outcomes rather than services; by recovery rather than dependence; by prevention and early intervention rather than proper management of waiting lists; by growth in local public-private partnerships rather than expanded government operations; and by flexible funding through managed care approaches rather than fee-for-service methods.

1. Steering Committee. With completion of Blue Ribbon Commission work, the Department of Health and Family Services should appoint a Mental Health Steering Committee to lead in implementing Commission recommendations. The Steering Committee should have 18 members reflecting stakeholder groups and Commission composition. The Committee's first task will be to work with legislators to draft a bill enacting Commission recommendations for introduction in the Fall 1997 legislative session. The Committee will also serve as a link to the Department's Long-term Care Redesign Initiative and to the Governor's Council on Mental Health.
2. Carve Out From Medicaid. If enacted, the proposed legislation will establish a new approach to managing Wisconsin's mental health and alcohol and other drug abuse care (i.e., "behavioral health") for persons covered by the Wisconsin Medical Assistance Program who are not already involved in a managed care plan (that is, excluding those already in the AFDC/Healthy Start HMO initiative). Effective January 1999, the proposed law will:
 - Carve out from physical health all Medicaid expenditures for behavioral health for the population to be served by this initiative;
 - Assign monthly Medicaid payments to the designated local agency using one of these managed care approaches—capitation (average amount per Medicaid-enrolled person) or case rate (amount per Medicaid-enrolled person served according to level-of-need grouping).
 - Make the local designated agency responsible for arranging and funding all necessary services in the behavioral health benefits package for enrolled persons.
 - Reinvest savings resulting from managed care in local behavioral health expansion, prevention, and early intervention.
3. Local Designated Agencies. Under the legislation to be proposed, counties and tribes will assume local designated agency roles, selecting from a variety of existing and new organizational options. The counties will have these options: 1) a single county department of community programs; 2) a multi-county department of community programs; 3) a department of human services; 4) a new quasi-public behavioral health authority established by the county; or 5) delegating these roles to one or more private managed care organizations by action of the county. The tribes will have a new option to become the local behavioral health authority.

4. Performance Contracts. Effective January 1999, the proposed legislation will also incorporate performance contracts to monitor state and federal funding managed by local designated agencies. The Steering Committee will review and approve implementation of performance contracting based on Wisconsin enabling legislation. Key issues to be addressed include:
 - Definition of consumer and system outcomes and measurable indicators to be used;
 - DHFS capacity to provide required technical assistance and quality assurance;
 - Common data elements to be collected by local designated agencies and by all Medicaid behavioral health providers;
 - Significant representation of stakeholder groups on the boards of local designated agencies—county board supervisors or tribal officers, consumers and their families, citizens, and providers;
 - Funding and minimum requirements for implementation of local prevention and early intervention activities;
 - Priority use of contract funds to assure assessment and services for children and adolescents with serious emotional disturbance and for adults and older persons with serious and persistent mental disorder;
 - Availability of a local integrated approach to children’s services that coordinates mental health services with education, juvenile justice, social services, and other services.

5. Expanded Managed Care Pilots. Starting in 1999, a variety of pilot projects will be established by DHFS and local designated agencies to explore managed care features, such as consumer choice among qualified organizations, integration of behavioral and physical health care benefits, and increased risks and incentives in performance contracts. The results of these pilot projects will be analyzed to guide DHFS managed care approaches to be continued, expanded, ended, or piloted for 2003 and beyond. If care continues to be managed locally at this next phase, with increasing responsibilities and risks for the managed care entity, a process must be defined to allow counties to choose to opt out of this role.

6. Preparation for 1999 Behavioral Health Initiatives. The Blue Ribbon Commission recommends prompt action on proposed new directions for Wisconsin’s mental health system. Additional steps needed consist of:
 - applying for federal Medicaid waivers to allow the behavioral health carve out, expanded local pilot projects, and specify the 1999 benefits package;
 - increasing statewide technical assistance on prevention, recovery, outcomes, performance contracting, stakeholder involvement, and risk-sharing mechanisms;

- maximizing federal Medicaid funds, Division of Vocational Rehabilitation funds, state and federal funds for affordable, scattered site housing; and maintaining at least the 1997 level of Community Aids and county funding for mental health;
- strengthening the mental health system by developing expanded working relations with university systems;
- working with the Social Security Administration to increase consumer incentives to work without losing essential benefits;
- identifying expectations regarding consumer choice of specific providers and the dispute resolution and grievance processes.

Conclusion

Wisconsin's mental health system is at a crossroads. The Report of the Governor's Blue Ribbon Commission on Mental Health outlines a vision of a recovery-oriented mental health system that promotes self-determination and quality of life rather than dependence for persons of all ages with mental disorders. The Report also emphasizes prevention and early intervention of targeted mental disorders. The remarkable aspect of the Report is that all stakeholder groups represented on the Commission agreed on these key approaches.

The next step in improving mental health services in Wisconsin is implementation of these recommendations. The Report is submitted to the Governor with the intent that it will guide development of mental health services for Wisconsin residents well into the twenty-first century.