System Priority: Mental Health and Mental Disorders
Objective 1: Screening and Referral (Logic Model)

**Long-term (2010) Subcommittee Outcome Objective:** By 2010, 80 percent of State-administered employee group health plans, Medicaid-funded programs, BadgerCare, and SSI managed care will, by contract, incorporate questions for mental health problems into their screening and referral processes.

Long-term outcome objective updated as of: Sept 2004

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Designated state staff to guide and develop the process.</strong></td>
<td><strong>General</strong></td>
<td><strong>Participation/Reach</strong></td>
</tr>
<tr>
<td></td>
<td>A mental health workgroup will be formed to oversee the implementation of all the Mental Health and Mental Disorders Subcommittee objectives.</td>
<td>By June 1, 2003, a mental health screening workgroup will include representatives from the following systems/organizations that include diverse racial/ethnic groups: Consumers/Family members across the lifespan Education Corrections - jails/prisons Health Care - health maintenance organizations, primary care Social Services Child care and early childhood Local health departments Tribes</td>
</tr>
<tr>
<td></td>
<td>The mental health workgroup will meet at least 4-6 times to develop a Partnership Plan and oversee its implementation. The partnership plan will identify how the partner systems will work together to achieve the objectives.</td>
<td>By June 1, 2003, a mental health screening workgroup will be established with the goal to engage partner systems in the change process and motivate partner systems towards commitment to collaborate in screening and referral for mental health disorders, with particular attention to the use of screening tools that meet standards of cultural competency.</td>
</tr>
<tr>
<td></td>
<td><strong>Screening</strong></td>
<td><strong>Budget/Policy</strong></td>
</tr>
<tr>
<td></td>
<td>An expert panel will be convened to identify a variety of valid screening tools for mental disorders that can be utilized by the partner systems.</td>
<td>By December 31, 2005, necessary statutory language changes or biennial budget items needed to implement universal and culturally competent mental health screening in educational, corrections, and primary care settings will have been approved by the legislature.</td>
</tr>
<tr>
<td></td>
<td>The expert panel will have completed its work.</td>
<td>By February 2005, each partner system will be committed to using the selected screening tools and processes.</td>
</tr>
<tr>
<td></td>
<td>Each partner system will have identified key personnel for instituting change.</td>
<td>By May 2005, each partner system will have adopted use of mental health screening as a formal policy/practice.</td>
</tr>
<tr>
<td></td>
<td>Pilot testing of preferred screening tools will occur in each partner system.</td>
<td>By November 1, 2005, appropriate partner system staff will have been trained and will be</td>
</tr>
</tbody>
</table>

**Logic Model – System Priority: Coordination of State and Local Public Health System Partnerships – Objective 1**
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-term</th>
<th>Medium-term</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment of time and fiscal support for existing staff/experts to develop and carry out trainings identified in the objective.</td>
<td>The results of the pilot testing will be evaluated. Each partner system will identify its training needs to ensure that appropriate staff can administer screening tools.</td>
<td>Local mental health agencies and organizations</td>
<td>Screening</td>
<td>knowledgeable and able to conduct mental health screenings.</td>
<td></td>
</tr>
<tr>
<td>The time of all identified individuals to develop the partnerships that will be needed to achieve success.</td>
<td>Referrals Each partner system will have a list of referral sources appropriate for its population. Each partner system will have developed or revised referral procedures. Appropriate staff in each partner system will have been trained on referral procedures.</td>
<td>County and other public organizations</td>
<td>By May 1, 2003, an expert panel will identify a variety of valid mental health screening tools that could be used by collaborating partner systems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiscal support for needed materials such as training materials and data collection.</td>
<td>Professional Education/Training A number of professional schools will have planned to incorporate mental health screening into their curricula.</td>
<td>Wisconsin Department of Health and Family Services</td>
<td>By July 1, 2003, key partner system personnel will be identified and educated about the available screening tools identified by the expert panel.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance learning technologies to communicate with partners, including consumers/families across the life span, representatives from diverse racial/ethnic groups and cultures.</td>
<td>Wisconsin Department of Health and Family Services Contracts Contract language will be added to new Wisconsin Department of Health and Family Services contracts requiring mental health screening.</td>
<td>Legislature</td>
<td>By November 1, 2003, each partner system will have selected one or more screening tools to address specific targeted population needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure consultation, technical assistance, and resource support from all partner systems.</td>
<td></td>
<td>Statewide professional organizations (e.g., Wisconsin Health and Hospital Association, Wisconsin Primary Health Care Association, Wisconsin Nurses Association, Wisconsin Medical Society, Wisconsin Public Health Association)</td>
<td>By May 2004, key screening staff in each partner system will have been offered at least one training opportunity to increase their awareness about mental health screening and the prevalence of mental disorders in specific populations served.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Logic Model – System Priority: Coordination of State and Local Public Health System Partnerships – Objective 1
### System Priority: Mental Health and Mental Disorders
**Objective 1: Screening and Referral (Logic Model)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By May 2004, the Mental Health Workgroup will obtain feedback on the viability of mental health screening in each partner system.</td>
<td>Referrals By November 1, 2005, all partner system professionals will have knowledge of referral sources and procedures pertinent to their system.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Referrals</strong> By June 2003, key personnel in each partner system will be familiar with referral sources for adults/children who may be in need of mental health assessment or treatment.</td>
<td>By January 1, 2006, all partner system staff will utilize referral procedures when screening identifies possible presence of a mental disorder.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By July 2003, each partner system will identify needed changes in referral procedures.</td>
<td>Professional Education/Training By September 2005, training on culturally competent mental health screening curriculum will be included in professional school curricula.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By December 2003, each partner system will complete a list of referral sources for adults/children who may be in need of mental health assessment or treatment.</td>
<td>By June 2006, health career students will become knowledgeable about use of mental health screening tools.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By December 2003, referral procedures will have been developed or modified, as necessary.</td>
<td>By June 2007, students will use mental health</td>
<td></td>
</tr>
</tbody>
</table>
## System Priority: Mental Health and Mental Disorders
### Objective 1: Screening and Referral (Logic Model)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wisconsin Department of Health and Family Services Contractors</td>
<td>screening tools when they attain professional status.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By July 2004, Wisconsin Department of Health and Family Services contractors will be informed and educated about new contract requirements for mental health screening. These will include: local health departments, Tribes, primary health care providers, Medicaid providers (fee-for-service and Medicaid health maintenance organizations), agencies covered under the state/county contract, and state grantee agencies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By January 2005, individuals of all ages entering programs covered by identified state contracts will be screened for mental disorders.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Health Priority: Mental Health and Mental Disorders
## Objective 4: Access to Care (Logic Model)

### Long-term (2010) Subcommittee Outcome Objective:

**2a:** By 2010, Wisconsin’s public mental health clients who have access to "Best Practice" mental health treatments will increase by 10 percent.

**2b:** By 2010, Wisconsin's public mental health clients who have access to "Evidence-based" mental health treatments will increase by 10 percent.

(Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 3)

### Inputs

<table>
<thead>
<tr>
<th>Designated state staff to guide and develop the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureau of Community Mental Health/Division of Supportive Living</td>
</tr>
<tr>
<td>Division of Public Health</td>
</tr>
<tr>
<td>Wisconsin Medicaid – Division of Health Care Financing, Department of Health and Family Services</td>
</tr>
<tr>
<td>Office of the Commissioner of Insurance</td>
</tr>
<tr>
<td>Fiscal support to convene a mental health workgroup that will consist of identified leaders in the mental health field</td>
</tr>
</tbody>
</table>

### Activities

| Coalitions will be established/joined for enacting parity, enacting legislation to control health insurance costs for small businesses, and addressing other barriers to insurance. |
| Uninsured populations will be identified. |
| Reasons for lack of insurance will be identified. |
| Solutions to lack of insurance will be identified. |
| Strategies to implement solutions to lack of insurance will be put in place. |
| Key parties (e.g., businesses, health insurers, legislators) will be contacted and educated. |
| Public education will be provided through the media. |

### Outputs

| Healthcare and HMOs |
| Primary care |
| Education |
| Corrections - jails/prisons |
| Social services |
| Aging-including - area agencies on aging |
| Child care and early childhood |
| Local health departments |
| Tribes |
| Local mental health agencies and organizations |

### Participation/Reach

| By 2003, there will be an increase, as measured by standard polling, in the percentage of the population that supports increased access to health insurance coverage. |
| By 2003, citizens and policymakers will be aware of the hidden costs in failing to provide health insurance coverage to all persons. |
| By 2003, changes that reduce insurance costs for small businesses will be identified. |
| By December 2003, key stakeholders (e.g., providers, insurers, policymakers) will “buy-in” to best practice guidelines. |
| By 2004, parity legislation will be passed in Wisconsin. |
| By 2004, major state healthcare contracts (e.g., |

### Short-term 2002-2004

| By 2005, policy changes will expand access to insurance through Wisconsin Medicaid and BadgerCare. |
| By April 2005, legislators will have a clearer understanding of what they are “buying” when funding public mental health services and will therefore be more willing to do so. |
| By 2005, legislation will implement small business health insurance reform that will reduce health insurance costs for small businesses and increase access to insurance for employees. |
| By 2005, all commercial group health insurance policies in Wisconsin will implement the parity provisions. |

### Medium-term 2005-2007

### Long-term 2008-2010

By 2010, reduce by 10 percent the proportions of the population that reports difficulties, delays, or the inability to receive "Best Practice" mental health treatment.

By 2010, increase the number of people with a mental health need to have timely access to evidence-based treatment.
### Health Priority: Mental Health and Mental Disorders

#### Objective 4: Access to Care (Logic Model)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>to oversee the implementation of the four Mental Health/Mental Disorders Subcommittee objectives.</td>
<td>Legislators and businesses will be educated about true costs and benefits of parity.</td>
<td>Public and county organizations</td>
</tr>
<tr>
<td>Fiscal support to develop and disseminate training materials on best-practice and evidence-based treatment.</td>
<td>Citizens and stakeholders will be informed about parity and mobilized to advocate with legislators.</td>
<td>Wisconsin Department of Health and Family Services</td>
</tr>
<tr>
<td>Distance learning technology to provide consultation on best-practice and evidence-based treatment.</td>
<td>Stories will be presented in media to educate the general population about the need for and value of mental healthcare as part of treating the whole person.</td>
<td>Legislature</td>
</tr>
</tbody>
</table>
| Partner systems with the needed expertise to achieve the identified objectives:  
- Business owners and their representatives  
- Insurance carriers  
- Legislators  
- Mental health professionals  
- Representatives from professional training schools | Model guidelines will be issued for access to treatment that identify timeliness standards, assessment and evaluation, treatment planning, and best practice or evidenced-based treatments. | Statewide professional organizations, public health system disciplines and partners:  
- Wisconsin Health and Hospital Association  
- Wisconsin Primary Health Care Association  
- Wisconsin Nurses Association  
- Wisconsin Medical Society | By 2004, three professional training schools for non-mental health specialists will agree to enhance their curricula to ensure that their professionals are better able to identify and respond to mental health disorders. | By 2005, policies and practices that are barriers to access will be eliminated. |
|  | Proposed changes will be made to program standards, policies, and statutes. | | By 2004, one new project involving technology to provide mental health treatment or consultation services to an underserved area will be implemented. | By 2005, insurers and providers will be using best practice guidelines for persons in need of mental health services. |
|  | Informational hearings will be conducted to inform a wide audience of proposals and receive feedback. | | By 2005, procedures will be in place for evaluating whether guidelines are being implemented properly. |  |
|  | Model guidelines will be disseminated for access to | | |  |
## Health Priority: Mental Health and Mental Disorders

### Objective 4: Access to Care (Logic Model)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| • Representatives from county human services  
• Tribes  
• Local health departments | treatment and best practice or evidence-based treatment.  
Ongoing monitoring of research will be conducted to identify potential revisions to guidelines over time.  
The Mental Health/Alcohol and Other Drug Abuse (AODA) Redesign Initiative will be implemented in four sites. Outcome and cost data will be determined.  
Proposals will be developed for best ways for state and county to share funding for public mental health services.  
Impact of recovery-oriented practices and prevention/early intervention practices will be documented and disseminated.  
Public awareness campaign will be implemented.  
Legislators will receive written information and face-to-face meetings educating them about efficacy of treatment and budget needs. | • Wisconsin Public Health Association | By 2005-2007, biennium funding for public mental health services will be based on number of persons needing services and better knowledge of the actual cost to provide services. Outcome indicators will guide funding decisions. (The actual level of funding may or may not increase based on the increase in the number of people served by the private sector, the use of more efficient services under managed care, etc.).  
By 2005-2007, biennium statutory changes will implement changes to state/county funding that result in adequate and equitable public funding statewide for mental healthcare.  
By 2007, two additional professional training programs for non-mental health specialists will enhance their training curricula. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number and type of mental health professionals serving the state will be identified.</td>
<td></td>
<td></td>
<td>By 2007, two additional projects will use technology to provide mental health treatment or consultation services to underserved areas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced training and education of allied professionals to provide mental health services will be planned.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expanded use of technology to provide mental health services or consultation to underserved areas will be planned.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Priority: Mental Health and Mental Disorders
Objective 1: Screening and Referral (Template)

Long-term (2010) Subcommittee Outcome Objective:
By 2010, 80 percent of State-administered employee group health plans, Medicaid-funded programs, BadgerCare, and SSI managed care will, by contract, incorporate questions for mental health problems into their screening and referral processes.
Long-term outcome objective updated as of: Sept 2004

- The key systems include education (K – 12 and higher education), corrections (jails and prisons for youth and adults), health care (health maintenance organizations, public health, primary care), social services (child welfare, W2), aging, child care and early childhood.

- Priority Rankings - The mental health/mental disorders subcommittee brainstormed a list of 86 potential objectives. These were initially narrowed down to 11. Two of the 11 related to screening: (1) to include mental health screening into all health care evaluations; and (2) screen and serve children having difficulties in childcare and school for emotional problems. A third objective addressed correctional options. These issues were combined to form the 10-year long-term outcome objective identified above.

- Achieving this 10-year outcome objective will contribute to the shared vision of the public health system of healthy people in healthy Wisconsin communities as demonstrated in (a) a more healthy Wisconsin population, (b) a more productive population, (c) reduced suicides across the life span, and (d) improved family relationships.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, this is a developmental objective.</td>
<td>Future source will be the contracts of the health plans and programs specified in the objective.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, this is a developmental objective.</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related USDHHS Healthy People 2010 Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter</strong></td>
</tr>
<tr>
<td>18 – Mental Health and Mental Disorders</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer</td>
<td>A person of any age who has received or currently is receiving mental health services.</td>
</tr>
<tr>
<td>Screening</td>
<td>The administration of one or more assessment tools to identify persons in need of more in-depth evaluation or treatment.</td>
</tr>
<tr>
<td>Screening tool</td>
<td>Those instruments and techniques (e.g., questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.</td>
</tr>
<tr>
<td>Referral</td>
<td>The process of assisting an individual to obtain services from a health professional who can assess and treat, if necessary, a suspected health condition.</td>
</tr>
<tr>
<td>Assessment</td>
<td>The process used to evaluate an individual’s presenting problems with an accompanying description of the reported or observed conditions that led to the classification or diagnosis of the individual’s illness.</td>
</tr>
<tr>
<td>Psychotropic medications</td>
<td>An anti-psychotic, an antidepressant, lithium carbonate or a tranquilizer, or any other drug used to treat, manage, or control psychiatric symptoms.</td>
</tr>
<tr>
<td>Partner systems</td>
<td>Service systems combining to work on increased screening in order to improve identification and referral of individuals who may be experiencing mental disorders. These include education, corrections, health care, social services, aging, child care, and early childhood.</td>
</tr>
<tr>
<td>Professional schools</td>
<td>Schools of advanced education for health care professionals. These might include, but are not limited to, schools of nursing, social work, medicine, and psychology.</td>
</tr>
</tbody>
</table>

Rationale:

Need
The impact of untreated mental illness on a wide range of public and private systems is demonstrated by the following statistics:

- A recent report by Wisconsin’s Legislative Audit Bureau noted that almost 20 percent of adults in the State’s corrections system were taking psychotropic medications, an indication of the presence of a mental disorder (Wisconsin Legislative Audit Bureau, 2001).
- Twenty to 25 percent of the single adult homeless population have a serious mental illness (Koegel et al., 1996).
- Children with serious emotional disturbance have the lowest high school completion rate among children with disabilities. Studies have found completion rates ranging from 23 to 61 percent (Clark and Davis, 2000).
- Suicide is the second leading cause of death for young people aged 15 to 24; suicide rates are highest among persons aged 65 years and older. The state suicide rate is three times higher than its homicide rate (Center for Disease Control and Prevention, 2001).
- Up to 50 percent of visits to primary care physicians are believed to be associated with or a consequence of a mental illness (Danzinger et al., 2000).
However, despite the impact of untreated mental illness, efforts to screen and identify mental illness are either inadequate or not well coordinated. Additionally, when screening does occur, adequate and appropriate referral mechanisms may not be in place to ensure that individuals identified as possibly experiencing a mental disorder are assessed by qualified practitioners and receive needed services (Department of Health and Human Services).

The U.S. Surgeon General in his 1999 report on mental health touches repeatedly on this issue of appropriate identification of mental disorders. Two examples relevant to this discussion include:

A sensible approach to suicide prevention that needs further study is to systematically screen 15- to 19-year-olds. Youth identified in this way should be referred for evaluation and, if necessary, treatment (page 341).

Primary care providers carry much of the burden for diagnosis of mental disorders in older adults. Unfortunately, the rates at which they recognize and properly identify disorders often are low. In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer (35 percent of the total) felt confident in prescribing antidepressants to older persons (page 457).

The Surgeon General’s vision for the future recognizes the need to use a variety of public and private agencies as “portals of entry” to mental health care. Among the systems he lists are primary health care, schools, child welfare, adult and juvenile corrections, and faith-based organizations (Navon et al., 2001).

Fortunately, this need to increase screening is accompanied by a wealth of potential tools for use. Through the subcommittee process alone, reports were identified that covered screening children in pediatric care settings (Moffic and Chavez-Rice, 2001), screens specifically for use by primary care physicians (Kramer, 2001), screening Temporary Assistance to Needy Families recipients (Yawn et al., 2001), and screening for women experiencing post-partum depression. Other tools can be identified through expert consultation and literature reviews.

Outcomes:
Short-term Outcome Objectives (2002-2004)
• By June 1, 2003, a mental health screening workgroup will be established with the goal to engage partner systems in the change process and motivate partner systems towards commitment to collaborate in screening and referral for mental health disorders, with particular attention to the use of screening tools that meet standards of cultural competency.

Budget/Policy
• By April 2004, the mental health workgroup will be formed to oversee the implementation of all mental health and mental disorders subcommittee objectives and will provide recommendations for the 2005-2007 Biennial Budget on statutory language changes needed to start screening for mental disorders in partner systems.

Screening
• By May 1, 2003, an expert panel will identify a variety of valid mental health screening tools that could be used by collaborating partner systems.
By July 1, 2003, key partner system personnel will be identified and educated about the available screening tools identified by the expert panel.

By November 1, 2003, each partner system will have selected one or more screening tools to address specific targeted population needs.

By May 2004, key screening staff in each partner system will have been offered at least one training opportunity to increase their awareness about mental health screening and the prevalence of mental disorders in specific populations served.

By May 2004, the Mental Health Workgroup will obtain feedback on the viability of mental health screening in each partner system.

**Referrals**

- By June 2003, key personnel in each partner system will be familiar with referral sources for adults/children who may be in need of mental health assessment or treatment.
- By July 2003, each partner system will identify needed changes in referral procedures.
- By December 2003, each partner system will complete a list of referral sources for adults/children who may be in need of mental health assessment or treatment.
- By December 2003, referral procedures will have been developed or modified, as necessary.

**Wisconsin Department of Health and Family Services Contractors**

- By July 2004, Wisconsin Department of Health and Family Services contractors will be informed and educated about new contract requirements for mental health screening. These will include: local health departments, Tribes, primary health care providers, Medicaid providers (fee-for-service and Medicaid health maintenance organizations), agencies covered under the state/county contract, and state grantee agencies.
- By July 2004, necessary changes will be made to administrative code to support required mental health screening (e.g., HFS 75).

**Medium-term Outcome Objectives (2005-2007)**

**Budget/Policy**

- By December 31, 2005, necessary statutory language changes or biennial budget items needed to implement universal and culturally competent mental health screening in educational, corrections, and primary care settings will have been approved by the legislature.

**Screening**

- By February 2005, each partner system will be committed to using the selected screening tools and processes.
  - By May 2005, each partner system will have adopted use of mental health screening as a formal policy/practice.
  - By November 1, 2005, appropriate partner system staff will have been trained and will be knowledgeable and able to conduct mental health screenings.
  - By December 31, 2006, 100 percent of individuals admitted to correctional facilities (e.g., jails, prisons, juvenile corrections) will be screened for mental disorders.
  - By December 31, 2006, 100 percent of local health departments will have incorporated mental health screening into their routine procedures for health screening and assessment.
  - By December 31, 2007, 100 percent of individuals entering social services will be screened for mental disorders.
• By December 31, 2007, 100 percent of individuals in identified programs for the elderly will be screened for mental disorders.

Referrals
• By November 1, 2005, all partner system professionals will have knowledge of referral sources and procedures pertinent to their system.
• By January 1, 2006, all partner system staff will utilize referral procedures when screening identifies possible presence of a mental disorder.

Professional Education/Training
• By September 2005, training on culturally competent mental health screening curriculum will be included in professional school curricula.
By June 2006, health career students will become knowledgeable about use of mental health screening tools.
By June 2007, students will use mental health screening tools when they attain professional status.

Wisconsin Department of Health and Family Services Contractors
• By January 2005, individuals of all ages entering programs covered by identified state contracts will be screened for mental disorders.

Long-term Outcome Objectives (2008-2010)
• By December 31, 2008, 100 percent of primary care providers (physicians/clinics), including those associated with health maintenance organizations, will have incorporated mental health screening into their routine procedures for health screening and assessment.
• By December 31, 2009, 100 percent of educational, child care and early childhood facilities will have incorporated mental health screening into their routine procedures for health screening and assessment.

Inputs: (What we invest – staff, volunteers, time money, technology, equipment, etc.)
• Designated state staff to guide and develop the process.
• Partner system representatives: individuals knowledgeable about key mental health issues and knowledgeable about screening processes in their systems and have authority to work towards the changes described in this document. These mental health priorities include: recovery-oriented services, culturally competent services, and trained professionals, and best practice services which eliminate stigma and recognize the importance of trauma and abuse.
• Fiscal support to develop and carry out the four mental health/mental disorders objectives.
• Investment of time and fiscal support of existing staff/experts to develop and carry out trainings identified in the objective.
• The time of all identified individuals to develop the partnerships that will be needed to achieve success.
• Fiscal support for needed materials such as training materials and data collection.
• Distance learning technologies to communicate with partners, including consumers/families across the life span, representatives from diverse racial/ethnic groups and cultures.
• Secure consultation, technical assistance, and resource support from all partner systems.
Outputs: (What we do – workshops, meetings, product development, training. Who we reach-community residents, agencies, organizations, elected officials, policy leaders, etc.)

Activities:

- **General**
  - A mental health workgroup will be formed to oversee the implementation of all the Mental Health and Mental Disorders Subcommittee objectives.
  - The mental health workgroup will meet at least 4-6 times to develop a Partnership Plan and oversee its implementation. The partnership plan will identify how the partner systems will work together to achieve the objectives.

- **Screening**
  - An expert panel will be convened to identify a variety of valid screening tools for mental disorders that can be utilized by the partner systems.
  - The expert panel will have completed its work.
  - Each partner system will have identified key personnel for instituting change.
  - Pilot testing of preferred screening tools will occur in each partner system.
  - The results of the pilot testing will be evaluated.
  - Each partner system will identify its training needs to ensure that appropriate staff can administer screening tools.

- **Referrals**
  - Each partner system will have a list of referral sources appropriate for its population.
  - Each partner system will have developed or revised referral procedures.
  - Appropriate staff in each partner system will have been trained on referral procedures.

- **Professional Education/Training**
  - A number of professional schools will have planned to incorporate mental health screening into their curricula.

- **Wisconsin Department of Health and Family Services Contracts**
  - Contract language will be added to new Wisconsin Department of Health and Family Services contracts requiring mental health screening.

Participation/Reach:
The Mental Health Workgroup will include representatives from the following systems/organizations that include diverse racial/ethnic groups:

- Consumers/Family members across the lifespan
- Education
- Corrections - jails/prisons
- Health Care - health maintenance organizations, primary care
- Social Services
- Aging
- Child care and early childhood
- Local health departments
• Tribes
• Local mental health agencies and organizations
• County and other public organizations
• Wisconsin Department of Health and Family Services
• Legislature
• Statewide professional organizations (e.g., Wisconsin Health and Hospital Association, Wisconsin Primary Health Care Association, Wisconsin Nurses Association, Wisconsin Medical Society, Wisconsin Public Health Association)

**Evaluation and Measurement**
The four mental health objectives combined will lead to the long-term outcomes identified above. The following table identifies the various objectives and measures that will allow us to evaluate our achievements.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A healthier Wisconsin population</td>
<td>Add questions to Wisconsin’s Family Health Survey to measure prevalence of mental disorder among children and adults</td>
<td>Family Health Survey-Department of Health and Family Services</td>
</tr>
<tr>
<td></td>
<td>Questions on mental health status</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>A more productive Wisconsin population</td>
<td>Add questions to Wisconsin’s Family Health Survey to identify degree to which mental or emotional problems interfere with functioning</td>
<td>Family Health Survey-Department of Health and Family Services</td>
</tr>
<tr>
<td>Reduced suicides across the life span</td>
<td>Number and rate of suicides by age group</td>
<td>National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics</td>
</tr>
<tr>
<td></td>
<td>Number of students in grades 9 through 12 who reported suicide attempts that required medical attention in the 12 months preceding the survey</td>
<td>Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
</tr>
<tr>
<td>Improved family relationships or social connectedness</td>
<td>Survey questions</td>
<td>Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
</tr>
</tbody>
</table>
Survey questions

Promotion

National Health And Nutrition Examination Survey

Increased screening for mental health problems

Questions that have been added to the Wisconsin’s Family Health Survey

Family Health Survey-Department of Health and Family Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access</td>
<td>Number of adults aged 18 years and older who report symptoms of depression and who report that they received help from a mental health professional divided by number of adults aged 18 years and older who report symptoms of depression</td>
<td>Healthy People 2010 measure-- National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration</td>
</tr>
</tbody>
</table>

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Access to Primary and Preventive Health Services: Screening for mental disorders, with appropriate referrals, will increase the likelihood that persons will see not only mental health professionals but primary care physicians as well. This will occur because the mental health professionals may help individuals identify certain primary health care needs or prevention and early intervention as some individuals will go to their primary care physicians to receive medications to treat their mental disorders.

Alcohol and Other Substance Use and Addiction: Rates of co-occurrence of mental disorders with alcohol and other substance abuse disorders are significant. Identification of a mental disorder will therefore also increase identification and referral of treatment for persons of all ages with alcohol and other drug abuse disorders under Wisconsin Administrative Rule HFS 75 (2001).

High Risk Sexual Behavior: High risk sexual behavior can occur in response to an unsatisfactory or traumatic life situation. Screening for mental disorders may identify individuals of all ages who are in such situations and provide for earlier intervention, screening and referral. This may lead to a reduction in adults/children engaging in high risk sexual behavior.

Intentional and Unintentional Injuries and Violence: Almost 600 people die from suicide each year in Wisconsin. Many others attempt, but do not complete, suicide. The state suicide rate is three times higher than its homicide rate. Increased screening should allow us to identify persons at risk for suicide and intervene before their mental health status deteriorates.
Social and Economic Factors that Influence Health: Persons with mental disorders have a higher mortality rate than the general population and are less likely to receive basic medical care. By identifying and treating mental disorders, general health can be improved.

Tobacco Use and Exposure: Persons with mental disorders have high rates of tobacco use. It is important to note that the same medications used to treat depression are often given to individuals trying to quit smoking. Screening, referral, and treatment may positively influence tobacco use.

Integrated Electronic Data and Information Systems: Lack of reliable data about prevalence and outcomes of treatment for mental disorders makes it difficult to address mental health issues in many systems. Integrated data systems is a critical piece for systems change throughout the State DHFS and other partners who are working to evaluate outcomes and client population profiles.

Community Health Improvement Processes and Plans: Because of the huge impact of mental health and mental illness on society (as noted in the “rationale” section) any community health improvement must address screening, referral, and treatment for mental disorders.

Sufficient, Competent Workforce: The short supply of trained mental health professionals, especially those specializing in children and older adults and those culturally competent to work with diverse racial/ethnic groups (e.g., Hispanic, Native American), is a system barrier to screen and identify potential mental disorders. Adequate referral sources do not exist. Wisconsin needs to evaluate workforce and population need for service gaps.

Equitable, Adequate, and Stable Financing: Financing is a major issue. Public systems are struggling to meet the needs of current clients and limits on private insurance coverage for mental disorders often leaves individuals and their families with no way to pay for identified treatment needs. Identification of additional persons needing treatment will be futile if they are not able to then obtain access to treatment resources.

Significant Linkages to Wisconsin’s 12 Essential Public Health Services

Monitor health status to identify community health problems: Screening for mental disorders in multiple systems enhances our ability to monitor health status and provide public input into this critical area.

Identify, investigate, control, and prevent health problems and environmental health hazards in the community: Screening for mental disorders allows us to identify the presence of potential mental disorders in targeted populations of the community across the life span.

Promote community partnerships to identify and solve health problems: The process described in this objective will develop partnerships across systems that will benefit both systems. For instance, if schools can better identify children/youth with mental disorders and assist families and refer to treatment, then the schools can better fulfill their mission to educate.

Create policies and plans that support individual and community health efforts: Improved policies for screening and referral for mental disorders will support this mission, which values a family focused approach.
Link people to needed health services: This objective will improve access to treatment and improve health outcomes for individuals and communities.

Conduct research to seek new insights and innovative solutions to health problems: Mental health screening may assist with data to help us better understand the prevalence of persons with mental disorders in various systems.

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010
This objective for Mental Health connects with all three overarching goals.

Protect and promote health for all: Screening for and early identification of mental disorders will reduce the severity and impact of mental disorders on the population.

Eliminate health disparities: While screening and referral alone cannot reduce disparities in treatment for mental illness across sub-populations, it can serve to increase identification of potential mental disorders across sub-populations and educate all about the effectiveness of treatment.

Transform Wisconsin’s public health system: The environment of the public health system makes it the ideal system to identify persons with mental disorders without the stigma that is attached to “mental health” services. By becoming more informed and competent in identification and referral, the public health system will meet (develop/actualize) its potential to reduce the devastating effect of mental disorders on all individuals and all communities.

Key Interventions and/or Strategies Planned:
- Mental Health Workgroup develops implementation plan and gets ‘buy-in’ from partner systems.
- Expert panel identifies valid and appropriate screening tools for review by partner systems.
- Partner systems identify tool they feel best fits their needs.
- Partner systems participate in field-testing and evaluation of screening tools.
- Partner systems evaluate their referral procedures and practices and make revisions, as needed.
- Staff from partner systems are trained on new screening tools and referral policies.
- Professional schools incorporate training on mental health screening into their curriculum.
- Department of Health and Family Services incorporates mental health screening and referral requirements into relevant contracts.

References:


Health Priority: Mental Health and Mental Disorders
Objective 2: Discrimination/Anti-Stigma (Template)

Long-term (2010) Subcommittee Outcome Objectives

2a: By 2010, an additional 15 percent of the general public will demonstrate an understanding that individuals with mental health disorders can recover through treatment to lead productive, healthy, and happy lives.

2b: By 2010, an additional 15 percent of the general public will demonstrate the belief that individuals with mental health disorders are capable of sustaining long-term productive employment.

Long-term outcome objective updated as of: Sept 2004

Achieving this 10-year outcome objective will contribute to the shared vision of the public health system of healthy people in healthy Wisconsin communities as demonstrated in a more healthy Wisconsin population, a more productive population, reduced suicides across the life span, and improved family relationships.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, this is a developmental objective.</td>
<td>Questions will be added to a statewide survey such as the Behavioral Risk Factor Survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.3 suicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population). Target: 5.0 suicides per 100,000 population.</td>
<td>Healthy People 2010, November 2000, United States Department of Health and Human Services, cites the following sources for this baseline data: National Vital Statistics Systems, Centers for Disease Control and Prevention, National Center for Health Statistics</td>
</tr>
<tr>
<td>43% of persons aged 18 years and older with serious mental illness were employed in 1994. Target: 51 percent.</td>
<td>Healthy People 2010, November 2000, United States Department of Health and Human Services, cites the following sources for this baseline data: National Health Interview Survey, Centers for Disease Control and Prevention, National Center for Health Statistics</td>
</tr>
<tr>
<td>See Appendix A for baseline and target data on adults with mental disorders receiving treatment.</td>
<td>Healthy People 2010, November 2000, United States Department of Health and Human Services, cites the following sources for this baseline data: Epidemiologic Catchment Area Program, National Institutes of Health, National Institute of Mental Health; National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Assistant Secretary, National Co-Morbidity Survey, Center for Mental Health Services</td>
</tr>
<tr>
<td><strong>Federal/National Baseline</strong></td>
<td><strong>Federal/National Sources and Year</strong></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>24 States had an operational mental health plan that addressed mental health crisis interventions, ongoing screening, and treatment services for elderly persons in 1997. Target: 50 States and the District of Columbia.</td>
<td>National Technical Assistance Center for State and Mental Health Systems, National Association of State Mental Health Program Directors, National Research Institute; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services</td>
</tr>
</tbody>
</table>

### Related USDHHS Healthy People 2010 Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – Mental Health and Mental Disorders</td>
<td>Improve mental health and ensure access to appropriate, quality mental health.</td>
<td>18-1</td>
<td>Reduce the suicide rate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-4</td>
<td>Increase the proportion of persons with serious mental illness (SMI) who are employed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-7</td>
<td>(Developmental) Increase the proportion of children with mental health problems who receive treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-9</td>
<td>Increase the proportion of adults with mental disorders who receive treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-10</td>
<td>(Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-11</td>
<td>(Developmental) Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness (SMI).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-13</td>
<td>(Developmental) Increase the number of States, Territories, and the District of Columbia with operational mental health plan that addresses cultural competence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-14</td>
<td>Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer</td>
<td>A person who has received or currently is receiving mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement of Stigma</td>
<td>A substantial increase in the general public’s acceptance of mental illness as a health condition that is common and a real illness, and that can be successfully treated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Refers to the signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>Refers collectively to all diagnosable mental disorders which are health conditions characterized by alterations in thinking, emotion or mood, and behavior (or some combination thereof) associated with distress and/or impaired functioning (U.S. Department of Health and Human Services, 1999).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>As accepted by the Wisconsin Council on Mental Health in July 2001, recovery from a mental illness means the process of growth over time in the improvement of a person’s attitudes, feelings, values, goals, skills, and roles. Recovery is measured by a decrease in symptoms of illness and an increase in the maintenance of the person’s highest level of health and wellness, stability, self-determination, and self-sufficiency. Recovery means the development of hope; dignity; a new and valued sense of self, meaning and purpose; and quality of life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>Means disqualification from social acceptance, derogation, marginalization and ostracism encountered by persons with mental illness or persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations, and acts of discrimination (Wisconsin State Statutes, Mental Health Act: s.51.032 Wis Stats).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale:**

In *Healthy People 2010*, Volume II, Chapter-18, Mental Health and Mental Disorders, Objectives 18-1,18-4,18-7,18-9,18-10,18-11,18-13, and 18-14, pp. 18-3-22, the stated goal is to “*Improve mental health and ensure access to appropriate, quality mental health services.*”

**Further Rationale:**

- Stigma is a major obstacle common to both mental illness and mental health problems, with an associated “labeling process” that occurs. Nearly two-thirds of all people with distinguishable mental disorders do not seek treatment (U.S. Department of Health and Human Services, 1999, page 6). The stigma is imposed by others or self-perceived; the barriers created by large-scale discrimination are real. They prevent people from getting treatment and they affect the individual’s quality of life. Stigma leads people to avoid living, socializing or working with, renting to, or employing people with mental health problems or persons with severe mental disorders (U.S. Department of Health and Human Services, 1999). Consumers, their families, and others experience discrimination and stigma covertly and overtly from multiple sectors in their communities.
- Title VI of the Federal Civil Rights Act and Limited English Proficiency guidelines requires that we provide services in the language of the client and in a culturally competent manner.
- The Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 require the provision of effective services to applicants/clients who have disabilities.
• The Wisconsin Department of Health and Family Services and other partners/stakeholders are committed to ensuring that all individuals are treated fairly and are not discriminated against based on sexual orientation, religion, age, and other identified factors, such as a presence of mental illness.

• Efforts of mental health professionals, as well as the significant and encouraging advances in new medications and evidenced-based treatment combined with comprehensive screening, identification, and referral may be undermined if the stigma of mental illness is not directly and effectively reduced and overcome.

• Mental health professionals may limit the potential of persons with mental illness through (1) reluctance to treat persons with severe or persistent mental illness; (2) lowered expectations and paternalistic attitudes while working with consumers; (3) utilization of stigmatizing diagnostic labels and also not focusing on consumers’ strengths, potential for recovery, self-identified dreams and deficits, and choices; (4) limited use and prescription of newer medications due to cost constraints; and (5) treatment approaches that promote the management of psychiatric symptoms, rather than focusing on the person’s comprehensive needs and hopes and optimizing the individual’s recovery.
  - Mental health professionals are in a position to offer hope, recovery, and empowerment; they can convey factual and positive recovery-oriented information to the public and convey contributions and “real life” recovery of persons with mental illness.

• A key point is that persons with mental illnesses can be treated and, with support, can recover, as can individuals with physical illnesses. The efficacy of mental health treatments is well documented (U.S. Department of Health and Human Services, 1999).

Prevalence

• The number of individuals with conditions included in the broad label of “mental illness” is far larger than most of the public realizes. The incidence of mental illness in Wisconsin affects an estimated 5.7 percent (200,000) of individuals over the age of 18 in the population (Wisconsin Department of Health and Family Services). For example, nearly 12 percent of children and adolescents suffer from one or more diagnoses of mental illness.

• Suicide is a significant public health problem and ranks as the eighth leading cause of death in the United States and Wisconsin. Suicide was responsible for 598 Wisconsin resident deaths in 1999. It is the second leading cause of death among young people in Wisconsin aged 15 to 24 years, accounting for 99 deaths (automobile accidents was first). Young males between the ages of 20 and 24 had the highest suicide rate in Wisconsin for calendar year 1999 (Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, 1999).

• Mental illness and mental disorders are also prevalent in the elderly population, and proportionally more elderly persons commit suicide than persons in any other age group. Almost five million adults in the United States suffer from a severe and persistent condition included in the general diagnosis of mental illness (Source: Mental Health Early Intervention, Treatment and Prevention Act of 2000).

• Nationwide, nearly 700,000 persons with active symptoms of a serious mental illness are admitted to jails each year. They make up about 7 percent of the jail population. Persons with serious mental illness who do not receive treatment are over-represented in jail and prison populations, especially women and minorities.

• Persons with mental illness who are arrested for non-violent, minor offenses are often jailed. They could be better served if diverted from the jail system to a community-based mental health treatment program.
The misunderstanding of mental illness and associated blame and stigmatization prevent many people with mental illness from seeking professional help. Many are unnecessarily incapacitated for weeks or months because their illness is untreated.

Wisconsin Population

According to the 1990-1999 U.S. Census, Wisconsin population reflects an increase of 15 percent for African Americans, 30 percent for Hispanic Latinos, and 32 percent for Asian Pacific Islanders. These percentages are going to continue to increase in the next 10 years.

The utilization of mental health services is far higher among affluent white individuals than any other socio-economic and ethnic group. In part, this reflects the societal reality that all health services are more completely utilized by affluent whites than any other group.

The stigma associated with poverty and minority status compounds the stigma of mental illness.

Mental health professionals who work with different cultural groups cite three reasons for the lack of utilization of mental health services by minority groups. They are:
1. Mental health providers are not able to speak the consumer’s language.
2. Cultural norms among the minority group may mitigate against the utilization of mental health services as they are currently offered, with stigma also a factor.
3. Mental health services are not presented in a culturally sensitive or recovery-oriented manner nor are they easily accessible to members of many minority cultures.

Anti-Stigma/Anti-Discrimination – Wisconsin Campaign

Many advocacy groups have worked to address discrimination and reduce stigma, though often they did not have sufficient factual data, effective materials, or the resources necessary to do so. Research is beginning to demonstrate that negative perceptions regarding severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness. Research has much to contribute to the development and evaluation of anti-stigma programs (U.S. Department of Health and Human Services, 1999).

Wisconsin has taken steps to develop an anti-discrimination/anti-stigma campaign, in May 2002 Wisconsin United for Mental Health, a coalition of key stakeholders was formed. Recovery training and work continues through the Recovery Task Force. The message promoted is that recovery is a process and that recovery provides hope to consumers to achieve an individual’s highest level of health and wellness, stability, self-determination, and self-sufficiency.

Research on discrimination and stigma shows that the most effective strategies combine education and personal contact with someone representing a stigmatized group. Wisconsin United for Mental Health discusses mental illness as common, real, treatable (May 2002).

A Wisconsin anti-discrimination/anti-stigma campaign through Wisconsin United for Mental Health would focus on a recovery-oriented, fact-based, and positive portrayal of persons with mental illness. The campaign would illustrate that persons with mental illness do lead productive lives within their communities, that with the availability of new medications and evidenced-based treatment, individuals with mental illness can and do recover. Approaches would include programs of advocacy, public education, and contact with persons with mental illness through schools and other institutions (U.S. Department of Health and Human Services, 1999). Wisconsin United for Mental Health has established a website for information, education, and public awareness: www.wimentalhealth.org.

Targeted components would address specific audiences in the population that can: (1) facilitate access to treatment; (2) facilitate the recovery process for persons with mental illness; (3) facilitate re-integration into community life for individuals with mental illness; and (4) change public
attitudes and perceptions about persons with mental illness and their families, thus reducing discrimination and stigma associated with mental illness.

- Wisconsin’s multi-faceted campaign can serve as a model for other states by providing effective, educational methods to address the devastating issues of discrimination and stigma in such areas as media coverage, housing, healthcare, and employment.
- The initial step by Wisconsin United for Mental Health is to create recognition with the media that discrimination and stigma toward persons affected by mental illness are problems within our communities and within the targeted sub-groups.
- Consumers of all ages and their families experience discrimination and stigma daily. They are the experts who know what they need, what they want, and what is best for them. Stigma has contributed to problems and discrimination which persons with mental illness face when trying to find employment, health insurance coverage, and housing. Consumers and family members will play an integral role in the reduction/elimination of discrimination and stigma in any activities promoted by Wisconsin United for Mental Health.

**Media**

- Discrimination/stigma is reinforced in the news media with biased stereotypes and myths perpetuated about persons with mental illness in news reports, entertainment programming, and advertising. As part of the implementation of this objective, there will be efforts to end exploitation of mental illness for humor or sensationalism, to encourage balanced and respectful portrayals in media coverage, and to promote accuracy in the use of medical terminology associated with mental illness and mental disorders.
- Despite the prevalence of mental illness, the general public continues to associate mental illness with the negative images of persons with mental illness. These images frequently shown by the media (in news reports and entertainment programming) perpetuate beliefs and myths, distort acts of violence, and stereotype persons with mental illness as villains and killers and something to be feared and shunned. These public beliefs persist despite research, which has found that the likelihood of violence is low.
- Research finds that the risk of violence is much less for a stranger than for a family member or person who is known to the person with a mental illness (U.S. Department of Health and Human Services, 1999). In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder.
- These negative media images reinforce negativity, fear, and misinformation about mental illness that are often communicated, knowingly or unknowingly, to children, creating a new generation of stigma and discrimination.
- One series of surveys found that selective media reporting reinforced the public’s stereotyping linking violence and mental illness and encouraged people to distance themselves from those with mental disorders (U.S. Department of Health and Human Services, 1999).
- Slurs and labels that enter into normal conversations often contain hurtful phrases – such as “psycho” or “lunatic” that are repeatedly found in conversations of children, teens, and adults. Those slurs and labels perpetuate and increase stigma associated with mental illness, and discrimination against specific individuals and their families.
- Persons with mental illness often are affected by “self-stigma” – a lowered self-concept and lowered self-esteem due to their perceived shame and rejection associated with mental illness, discrimination, and stigma.

**Outcomes**

**Short-term Outcome Objectives (2002 – 2004)**

Templates – Health Priority: Mental Health and Mental Disorders – Objective 2
By the year 2002:
• The “Anti-Discrimination/Anti-Stigma” Campaign (materials and 3 Modules Training curricula with a Strategic Plan) is initiated; key consumer/family spokespersons are identified.
• The Steering Committee adopts the name “Wisconsin United for Mental Health” and announces Web Site: www.wi.mentalhealth.org.
• An existing survey is identified or a Wisconsin survey or opinion poll is conducted to establish base-line data.
• Parity legislation passed in Wisconsin.
• Identify key leaders, high profile media figures, political and community leaders who understand the issues are identified and participate as spokespersons for Wisconsin United for Mental Health Initiative.

By the year 2003:
• Initiative begins in selected Wisconsin communities, media markets, other audiences, and business.

By the year 2004:
• Increase, as measured by standard polling, in the percentage of the population that understands the existence of discrimination and stigma (including self-stigma).
• Identify outcome measurements for improvement of stigma and discrimination reduction for persons with mental illness and for all other targeted groups.
• Secure the agreement of at least three professional training schools for mental health and non-mental health specialists agree to enhance their curriculum. Work to ensure that trained professionals understand stigma, discrimination and recovery and are better able to identify and respond to persons with mental health disorders.
• Identify and/or develop education strategies and awareness materials.

Medium-term Outcome Objectives (2005 – 2007)
By the year 2005:
• Increase the number of state residents who are knowledgeable regarding their right to mental health services through their insurance companies.
• Increase the number of state residents who have an understanding that persons with mental illness are fully capable of making meaningful positive contributions to society, do recover, and experience stigma and discrimination.
• Increase the number of factual, accurate reporting and media portrayal of persons with mental illness as measured through public reporting, through survey.
• Increase the number of insured individuals receiving medically necessary mental healthcare.

By the year 2006:
• A measured decrease in stigma is attained, based upon standard polling through survey tools created for each targeted group of providers and other system partners including consumer report.

By the year 2007:
• Add training opportunities for non-mental health specialists to enhance their mental health knowledge.

By the year 2008:

- Eighty percent of identified audiences will have received or been “reached” with “anti-stigma” materials and will have been provided the opportunity to participate in a variety of training opportunities.
- Implement legislation to provide resources and policies to increase employment opportunities for persons with mental illness, define employment guidelines for workplace accommodation, and strengthen anti-discrimination legislation.
- Have all baseline measures for data collection in place.
- Target identified sectors and the general public with campaign materials.

By the year 2010:

- Increase by 100 percent the proportion of the population that reports acceptance of mental illness as a health condition that can be successfully treated with recovery possible.
- Increase by 75 percent the portion of the population reporting that they perceive the media has increased factual reporting about persons with mental illness in their reports.
- Increase the number of individuals appropriately referred to treatment and not incarcerated.
- Increase and measure outcomes through evaluation that identifies at least 75 percent of mental health consumers reporting that they have benefited from targeted campaigns to address and overcome self-stigma.
- Increase and measure outcomes through evaluation that identifies 100 percent of identified audiences have received “anti-stigma” materials and have been provided the opportunity to participate in a variety of training opportunities.
- Reduce by 10 percent the proportion of the population that reports difficulties in, delays in, or the inability to receive "best practice" mental health treatment.
- Improve outcomes for persons with mental illness achieved through evaluation based on outcome measurements.
- Increase by 10 percent the number of people with a mental health need to have timely access to evidence-based treatment.
- Improve outcomes for persons with mental illness achieved through evaluation based on outcome measurements.
- Improve outcomes achieved through evaluation based on measuring stigma among the general public based on survey tools created for each targeted group within the general public.

**Inputs:** (What we invest – staff, volunteers, time money, technology, equipment, etc.)

- **Persons with mental illness:** Wisconsin United for Mental Health, a coalition of stakeholders directing a sustained, multi-faceted anti-stigma initiative. Directed efforts of consumers will become trained advocates and leaders.
- **Families:** Families, with members who have mental illness will continue to advocate through training and support to change and decrease stigma toward their family members.
- **Faith Communities:** Leaders of faith communities participate to increase communication and awareness of mental health illness, promote congregational interactions, write articles, sermons, promote counseling, and model mentor positive caring behavior toward persons with mental illness and their families.
- **Schools/Educators:** Schools will become a clearinghouse to expose students to a caring, fact-based explanation of mental illness, innovative treatment, and successful recovery by persons with mental illness.
• **Law Enforcement:** More comprehensive information, a more positive approach, and better training will enable law enforcement professionals in a variety of settings to ensure the well-being of individuals with mental illness, approach them more positively, and more effectively direct them towards appropriate treatment.

• **Emergency Room Personnel:** The initiative should result in improved emergency room personnel to make effective initial treatment and treatment by referral decisions.

• **Crisis Response Teams:** More comprehensive information, a more positive approach, and better training will enable crisis response professionals in a variety of settings to ensure the well-being of persons with mental illness, approach them more positively, and more effectively direct to appropriate treatment.

• **Healthcare Providers:** Anti-stigma efforts will educate healthcare providers to overcome misconceptions about persons with mental illness while providing them with effective ways to refer individuals to appropriate services.

• **Mental Health Providers:** Among the materials included in the Initiative are materials that emphasize recovery and educate mental health providers about discrimination, stigma and self-stigma encountered by persons with mental illness.

• **Employee Assistance Program (EAP) Managers/Benefits Managers:** These materials will ensure benefits managers understand/change policies and procedures to ensure work environments provide reasonable and accessible accommodation for persons with mental illness and that insurance plans cover medications and mental health treatment.

• **Corporations:** To provide jobs, to offer positive opportunities for persons with mental illness, and provide flexible hours and work environment accommodations for all to overcome both institutional stigma and self-stigma. Corporations can play an important and effective role in fighting stigma and discrimination.

• **Psychiatrists/Psychologists:** Exposure to effective treatment methods will help providers emphasize recovery-oriented research and evidence-based treatment models.

• **Landlords:** Important materials developed to impact and to increase the cooperation of landlords to make available increased safe, affordable housing units to persons with mental illness.

• **Media/Entertainment/Advertising Figures:** Media, entertainment, and advertising figures participate with an essential role in communicating positive, factual messages about mental illness and the positive contributions of persons with mental illness.

• **Political Leaders:** Wisconsin United for Mental Health will work to create bi-partisan support in the fight against discrimination.

• **State Government Agencies:** State agencies lead the fight against discrimination, they can lead by example through hiring increasing numbers of persons with mental illness.

• **Cultural Leaders:** Leaders of all racial, ethnic groups participate to disseminate anti-stigma information, while leading efforts to bring more effective treatment methods to persons with mental illness within their cultural groups.

• **Judges/Lawyers:** Judges and lawyers who are the first line of the criminal justice system will play an increasingly important role in helping persons with mental illness gain entry into appropriate treatment programs to provide jail diversion.

• **Stakeholder Corporations:** Pharmaceutical companies and others will play a catalytic role to create and disseminate factual information on mental illness, and recovery.

• **Training:** The anti-stigma initiative will promote a broad spectrum of training opportunities across a multitude of professions.

• **Funding:** The State and other external partners may provide both funding and resources.
• Materials: A variety of printed, video and on-line materials will be developed.
• Media: Various media contacts and partnerships formed and “messages” developed.
• Public Policy: A variety of public policy initiatives formed and activated. Public policy changed to expand the development of jobs and housing for persons with mental illness.

Output: (What we do – workshops, meetings, product development, training. Who we reach-community residents, agencies, organizations, elected officials, policy leaders, etc.)

Activities:
• Acknowledgement of the Issue of Discrimination
  The first step in solving a problem is acknowledging that it exists. While discrimination is an all too real problem for persons with mental illness, unfortunately it is not necessarily perceived with any urgency by the general population. The first short-term outcome is to identify an existing survey, or to conduct a Wisconsin survey, or opinion poll to establish base-line data to indicate the public’s perception of the issues of discrimination and stigma (including self-stigma reinforced by negative stereotypes of mental illness). The survey will address the public’s understanding that the messages transmitted by the media don’t indicate the “whole truth” about the wide range of persons with mental illness and the public’s understanding that mentally ill persons do make positive contributions to society.

• Create and Launch an Initial Anti-Stigma/Anti-Discrimination Campaign with Stakeholders/Key Leaders
  Another short-term goal is ensuring that key leaders and opinion-shapers utilize key anti-stigma communication strategies and materials. The goal is to increase the role of community leaders in communicating positive and accurate messages about persons with mental illness, which emphasize their recovery, success and positive contributions.

Target audiences for Wisconsin United for Mental Health include, but are not limited to:
(1) news and entertainment media, especially high profile local media figures;
(2) political leaders; and,
(3) community leaders (educational, faith-based and cultural).

Many Wisconsin communities will be targeted for airing anti-stigma media campaigns or will be selected to participate in an anti-stigma campaign with follow-up town meetings or round table groups to facilitate discussion around understanding mental illness and reducing discrimination and stigma in their communities.

• Develop a “Three Module” Anti-Stigma/Anti-Discrimination Campaign
  The Steering Committee may develop and implement a “three module” strategic planning process to identify and address target audiences with specific messages. The modules affect access to treatment, the recovery process, and reducing stigma.

<table>
<thead>
<tr>
<th>Module 1: Promote Access into Treatment</th>
<th>Module 2: Promote the Recovery Process</th>
<th>Module 3: Reduce Stigma, Change Perceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consumers and family members</td>
<td>• Consumers and family members</td>
<td>• Consumers, family members, and others</td>
</tr>
<tr>
<td>• Crisis response teams and emergency room staff</td>
<td>• Mental healthcare administrators</td>
<td>• Media/entertainment advertisement/ figures or spokespersons</td>
</tr>
<tr>
<td>• Law enforcement/ corrections staff</td>
<td>• Psychiatrists/mental healthcare providers</td>
<td>• Rehabilitation/benefits managers (emphasizing employment-based</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation/benefits managers</td>
<td>• Consumer-operated</td>
</tr>
<tr>
<td></td>
<td>(emphasizing employment-based)</td>
<td></td>
</tr>
</tbody>
</table>
- Healthcare professionals
- Mental healthcare staff
- Human services staff
- Education/schools
- Judges/lawyers
- Legislature/policymakers
- Education/schools
- Employers
- Landlords
- Insurance providers/benefit specialists
- organizations and other advocacy organizations
- Political leaders
- Governmental agencies staff
- Education/and other academic settings
- Cultural/religious leaders

### Promote Best Practice Models
Wisconsin will take steps to identify Best Practice standards and models. An Assessment of Needs tool for providers will be developed to determine current capacity to provide Best Practice mental health services and identification of challenges and opportunities to be a Best Practice delivery system. Collaboration between stakeholders and consumers/families in identifying and sharing of materials will assist in developing and maintaining their capacity to serve persons with mental illness from all communities. Best practice models in use by providers, consumers, or families, along with input from all other stakeholders and researched best practice mental health services, will be recognized.

### Develop Targeted Anti-Stigma Education/Communications Modules
Wisconsin will develop or obtain varied anti-stigma education, awareness, and communications materials to address targeted audiences in the “three module interactive” strategy. These materials will: (a) provide unique anti-stigma “take-away messages” to target audiences; (b) provide action steps or strategies that community or targeted group members can act upon; and (c) generate supportive public communication from key members of each target audience segment.

### Develop School-Based Anti-Stigma Curriculum Models
The short-term objective for this initiative will be to provide schools with models for identifying and assessing mental illness and responding effectively in making appropriate diagnoses and providing appropriate services and referrals. There is an immediate need to develop successful strategies within Wisconsin’s schools and higher educational settings to address discrimination and stigma associated with mental illness and to increase students’ understanding of mental illness and recovery. Additionally, there is a need to appropriately train educators and student peer groups to identify at-risk students as well as students with emotional problems. Curriculum units will be developed to address and identify discrimination and stigma. Currently, a disproportionate number of multi-ethnic/multi-racial children are represented in special education classes.

### Develop and Launch a Job Development Module
There are proven and effective strategies that public mental health agencies can promote and use within communities to increase the number of mental health consumers who successfully obtain long-term employment. Business partners and other key employer stakeholders will develop or obtain anti-stigma materials and develop the resources necessary to assist in launching an employment campaign for the promotion of job opportunities for persons with mental illness.

### Target Identified Sectors and the General Public with Campaign Materials
Starting with short-term and extending into medium-term outcomes, the initiative will seek to achieve a variety of outcomes including measured changes in public perceptions/opinions.

- There will be a significant percentage point increase in Wisconsin residents who indicate that they believe that persons with mental illness can be successfully employed, live in their community and recover.
- Among individuals who play a prominent role in helping persons with mental illness enter into formal treatment regimens:
  - One hundred percent of law enforcement personnel in Wisconsin will be offered the opportunity to participate in training programs that presents factual and accurate information about mental illness and recovery, provides crisis intervention training on effective interaction with persons with a mental illness, and provides access into appropriate treatment.
  - One hundred percent of emergency room staff in Wisconsin will be offered the opportunity to participate in training programs that helps them effectively recognize, screen, and assess mental illness disorders, and refer persons with mental illness into appropriate and accessible treatment settings.
  - One hundred percent of healthcare and mental healthcare professionals licensed to practice in Wisconsin will be offered the opportunity to participate in training to recognize that (1) stigma occurs within the mental health system and the broader healthcare system, and (2) that the effects of self-stigma for consumers may be due to treatment services received, providers’ attitudes, and the stigma associated with the label and diagnosis of mental illness in individuals of all ages.
  - One hundred percent of the healthcare professionals in Wisconsin will be offered the opportunity to participate in learning how to identify and refer patients to appropriate mental healthcare services with information on mental health screening tools or questions for early identification of mental health problems across the life span.
  - One hundred percent of mental health professionals licensed in Wisconsin will be offered the opportunity to participate in recovery-oriented and anti-stigma training.
  - One hundred percent of judges, corporation counsels, and lawyers in Wisconsin will be offered the opportunity to participate in training that presents (1) factual and accurate information about mental illness and recovery, (2) provides information outlining options for successful recovery and re-integration for individuals with mental illness and appropriate treatment, and (3) offers materials on how to refer persons with mental illness to the appropriate treatment programs.
- Among individuals who may play a prominent role in helping persons with mental illness to successfully recover:
  - One hundred percent of the Chief Executive Officers of companies with more than 100 employees in Wisconsin will receive materials outlining information about successful recovery for individuals with mental illness. These materials will encourage chief executive officers to hire persons with mental illness that is under treatment thus setting a tone in their corporations that encourages increased understanding and acceptance of mental illness.
  - One hundred percent of the psychiatrists/psychologists practicing in Wisconsin will be offered the opportunity to participate in training that is recovery-oriented and addresses self-stigma of consumers, along with stigma occurring within the mental health system, reviews Best Practice and utilization of new and emerging pharmacological/therapeutic treatments. This training may include evidence-based...
approaches, which promote research into Best Practice of clinically sound approaches to successful treatment of persons with mental illness.

- One hundred percent of landlords and management companies in Wisconsin with more than 100 rental units will receive anti-stigma materials illustrating successful recovery stories of persons with mental illness. These materials will include specific information on housing-based subsidy/guarantee programs for individuals with low incomes and the potential for these individuals to be successful tenants.

- One hundred percent of Employee Assistance Program (EAP) managers or benefits managers for corporations with more than 100 employees in Wisconsin will receive materials about (1) discrimination against persons with mental illness and information about the positive roles corporations can play in helping persons with mental illness successfully recover, and (2) strategies for providing accommodations in the workplace for persons with mental illness, and the promotion of understanding mental illness among employees.

- Among individuals who may play a prominent role in reducing stigma and discrimination while improving the general public’s perception of persons with mental illness:
  - One hundred percent of television and radio stations located in Wisconsin will be provided with public service announcements that address the issue of discrimination and stigma.
  - One hundred percent of the leaders of the executive and legislative branches of state government will be offered the opportunity to contribute footage to the various anti-stigma videos or other media materials produced for different target audiences.
  - All state agencies will institute specific employment guidelines describing the issue of discrimination/anti-stigma and detailing how accommodations shall be provided to persons with mental illness and what constitutes harassment toward persons with mental illness in the workplace. Education materials for all state employees will accompany the programs on recovery, workplace accommodation, and the positive and successful contributions made by persons with mental illness.
  - One hundred percent of educators at all levels in Wisconsin will receive curriculum materials on educating students with the facts about mental illness along with suicide prevention, early identification and referral to appropriate treatment for students, and suggested strategies to eliminate discrimination and stigma against persons with mental illness.
  - One hundred percent of religious leaders will receive materials on how they can help counsel persons with mental illness, and how they can refer persons with mental illness for appropriate treatment. These materials will also include materials to help members of their congregations recognize and overcome stigma and discrimination.
  - One hundred percent of the leaders of recognized community/cultural organizations will receive materials on discrimination and stigma.

- **Create Baseline Measures**
  At the same time public and private state and county mental health agencies, advocates, persons with mental illness and their families meet outcomes cited above, the Department of Health and Family Services may develop baseline measures to collect data on “achievement outcomes” (concrete results achieved).

- **Coordinated Stakeholder Outreach**
In many cases, individual stakeholders will have to come together in coordinated outreach efforts. For example, law enforcement officials and lawyers can work together to increase the number of persons with mental illness who are promptly referred to appropriate treatment alternatives rather than incarcerated. Similarly, employers and landlords can work together to make sure that persons with mental illness with effective treatment regimens have employment and housing opportunities.

- **Public Health Coordination and Collaboration**
  The biggest contribution public health will play will be in coordinating the many stakeholders involved in this effort to create and sustain a positive momentum in fighting stigma and discrimination.

- **Celebrate Achievement**
  This effort should recognize and celebrate achievement. This recognition of achievement will occur on two levels: 1) the celebration of individuals who successfully recover and once again make a sustained, positive contribution to society; and 2) the celebration of key “achievement goals”.

**Participation/Reach:**

Refer to previous section “Inputs” for a description of partners.

**Evaluation and Measurement**

The short-term efforts of this initiative will focus on creating essential materials and creating involvement among targeted audiences. In the medium term, this initiative will develop baseline measures while pursuing “activity” and “awareness” goals. In the long-term, this initiative will measure the attainment of “achievement” goals based on post-implementation results versus baseline levels.

These baseline measures will include, but not limited to:

1. Referrals by law enforcement for treatment [our goal will be to increase the percentage of persons identified with mental illness and appropriately referred to treatment].
2. Awareness and perception levels among the general population [to be measured by public opinion polls across many states, funded by key stakeholders and not public agencies, with the goal of increasing the percentage of the population with positive, informed opinions regarding persons with mental illness and their prospects for recovery].
3. Awareness, attitude and knowledge levels among target audiences (law enforcement, mental health professionals, emergency professionals, etc. – all mentioned above) relating to discrimination and working effectively with individuals with mental illness to be measured via responses to inexpensive mail-in survey forms – with the goal as increasing the percentage of each target population with positive, informed opinions regarding persons with mental illness and their prospects for entering into recovery].
4. Number of corporations: 1) instituting policies specifically to increase the employment of persons with mental illness; and/or 2) implementing employee assistance programs [to be measured through self-reporting, or via a website developed by key stakeholders – with the goal of increasing the number of corporations acknowledging the issue of mental illness with appropriate programs and policies].
5. Reduction in the number of persons with mental illness on SSI and/or the number of persons with mental illness and homeless [to be measured through state statistics of documenting that]
discrimination/stigma plays a direct role in preventing persons with mental illness from obtaining suitable employment and housing. These are indirect measures of reduced stigma and discrimination, and may well be tracked as results for a number of different initiatives.

6. Number of landlords instituting policies specifically to increase the number of housing units available to persons with mental illness who are also low income [to be measured through self-reporting, or via a website developed by key stakeholders documenting that stigma plays a direct role in preventing individuals with low incomes and mental illness from obtaining suitable housing].

7. Number of religious leaders who address the issue of discrimination/stigma in a sermon or other church publication during the calendar year [to be measured through self-reporting or via a website developed by key stakeholders – documenting that stigma can be overcome through community/cultural advocacy].

8. Number of educators in all settings who give students an assignment concerning discrimination/stigma during the calendar year [to be measured through self-reporting or via a website developed by key stakeholders – documenting that discrimination/stigma can be overcome through school-based efforts at all levels].

9. Percentage of youths and adults indicating self-stigma [to be measured by public opinion polls across many states targeting youths and adults, funded by key stakeholders and not public agencies – our goal will be to increase the percentage of the young people, especially young people who have been identified with some form of emotional disturbance, with positive, informed opinions regarding persons with mental illness and their personal prospects for recovery].

10. Percentage of consumers served by the public mental health system who report after survey interviews that they are in recovery.

11. Number of persons with severe mental illness who are in comprehensive employment;

12. Number of persons with mental illness in jail or prison.

13. Number of persons with severe mental illness who are living in safe, affordable housing.

14. Number of persons with mental illness who are homeless.

Wisconsin will use these and other similar baseline measures to determine the actual achievements of the various anti-stigma communications and education efforts.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Access to Primary and Preventive Health Services: All individuals pay a premium for their insurance coverage, but most health insurance plans discriminate against individuals with mental illness by requiring higher co-payments, allowing fewer inpatient or outpatient visit days, and limiting annual benefits. Treatment for mental illness is not on the same parity as other health conditions. Physicians and healthcare providers do not routinely screen for mental disorders or mental health problems. Screening for mental disorders, with appropriate referral, will increase the likelihood that persons will see not only mental health professionals but primary care physicians as well. This will occur because the mental health professionals may help individuals identify certain healthcare needs or prevention and early intervention as individuals will go to their primary care physicians to receive medications to treat their mental disorders. The misunderstanding of mental illness and associated blame and stigmatization prevent many persons from seeking professional help.

Alcohol and Other Substance Use and Addiction: Rates of co-occurrence of mental disorders with alcohol and other substance abuse disorders are significant. Identification and rates of treatment for persons with a mental disorder and/or substance abuse and other disorders for persons of all ages
remain at low levels due to continued stigma and discrimination and the lack of health insurance parity for services.

**Intentional and Unintentional Injuries and Violence:** (Suicide) Addressing the discrimination and stigma of mental illness will enhance recovery for persons with mental illness, reducing incidences of victimization, violence, trauma and abuse, reduced suicide attempts or completed suicides, and intentional self-inflicted injuries across the life span

**Social and Economic Factors that Influence Health:** The utilization of mental health services is far higher among affluent white individuals than any other socioeconomic and ethnic group. The stigma associated with poverty and minority status compounds the stigma of mental illness and mental disorders. Also, cultural norms among ethnic and cultural groups may mitigate against the utilization of mental health services as they are currently offered, with stigma as a factor.

**Tobacco Use and Exposure:** A research study (Glassman, 1988) shows that 60 percent of smokers in the United States (or 42 of 71 smokers) have a history of major depression as compared to data suggesting lifetime rates for the general population of about 18 percent. Individuals with chronic schizophrenia smoke at a rate of nearly 90 percent (U.S. Department of Health and Human Services, National Institutes of Health, 1997). This behavior causes significant physical health problems and increased mortality.

**Community Health Improvement Processes and Plans:** Because of the huge impact of mental health and mental illness on society, any community health improvement process must address mental health screening and early identification for all persons, referral to services, access to mental health treatment, focus on building trust and acceptance across diverse ethnic/racial groups and community partners, providing culturally competent healthcare, and eliminating stigma/discrimination for persons with mental disorders and their families.

**Coordination of State and Local Public Health System Partnerships:** Wisconsin United for Mental Health is a coalition of public and private partners dedicated to eliminate the stigma of mental illness and to educate the public and the media to the fact that mental illnesses are real, common, and treatable.

**Sufficient, Competent Workforce:** Within the specialty fields of geriatric and children's mental health specifically, a void exists of a sufficient supply of mental health professionals available, and a void of culturally competent trained workforce across Wisconsin.

**Equitable, Adequate, and Stable Financing:** The lack of healthcare financing continues as a major barrier to persons with mental disorders and mental health issues due to a lack of parity in health insurance coverage especially for ethnic/racial populations in Wisconsin. Stigma and discrimination continue to be leading contributors.

**Significant Linkages to Wisconsin’s 12 Essential Public Health Services**

*Identify, investigate, control, and prevent health problems and environmental health hazards in the community:* Improved access to mental health services will allow better control of the negative impact of mental disorders, prevent on-going difficulties and mitigate other health problems (since persons with mental illness have poorer health outcomes).
Educate the public about current and emerging health issues: A key aspect of Wisconsin United for Mental Health, a coalition of public and private stakeholders and partners, is the elimination of stigma in a multi-faceted effort to educate the public that mental illnesses are real, common, and treatable. The education awareness initiative will present the benefits of eliminating stigma through a sustained, ten-year plan of anti-stigma initiatives.

Promote community partnerships to identify and solve health problems: Wisconsin United for Mental Health (WUMH) is developing initiatives, which will work to promote a wide variety of community and corporate partnerships working collaboratively to combat and eliminate stigma and discrimination.

Create policies and plans that support individual and community health efforts: The planned activities of the anti-stigma/discrimination initiative (WUMH) will seek to create a variety of legislative and policy changes to effectively initiate regulatory, societal, and political change, which will benefit persons with mental illness, their families, the communities in which they live and the companies in which they work.

Enforce laws and regulations that protect health and insure safety: Link people to needed health services. Limitations on health insurance generally, and on insurance coverage for mental healthcare in particular, are major barriers to individuals receiving mental healthcare. This objective seeks to remove those barriers across all ethnic/racial populations and the life cycle.

Link people to needed health services: An integral component of the activities of the anti-stigma initiative (WUMH) will direct efforts promoting recovery, to educate the public that mental illnesses are real, common, and treatable, and to eliminate self stigma that occurs among consumers and their families. Educational awareness activities will work with many different target groups, such as health providers, educators, employers, police officers, attorneys, judges, corrections officers, emergency personnel, to maintain consumers in the community and to link them with treatment services so as to sustain consumers in their recovery. Another component of the initiative is to link people with health care services. Identification, screening, access, and treatment are critical to linking people to health services.

Conduct research to seek new insights and innovative solutions to health problems: Discrimination and stigma will be measured to assist in data collection and analysis to help identify and better understand the prevalence of discrimination and the effects of stigma for persons with mental disorders and their families in various systems including public perception, media distortion and news reporting.

Assure a diverse, adequate, and competent workforce to support the public health system: Improved access to mental healthcare inclusive of increased access to primary care that has expanded the supply of effective, evidence-based, recovery-oriented services provided by a culturally competent, trained and educated workforce.

Assure access to primary healthcare for all: An integral component of the anti-stigma initiative to help persons with mental illness (directly through the elimination of self-stigma or indirectly through the efforts of many different target groups) enter into sustained treatment regimens.

Foster the understanding and promotion of social and economic conditions that support good health: Success in this objective will require that the general public understands the relationship between current limitations in health insurance for mental illness and poor health outcomes, inclusive of a better
understanding of the effects of stigma and discrimination for individuals with these disorders and their families and poverty being a factor for many ethnic/racial groups.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

*Protect and promote health for all:* This goal can be best achieved by recognizing the need to provide recovery-oriented, culturally competent, and appropriate services, by recognizing the need for effective outreach to all eligible populations, and by understanding and addressing the effects of stigma, especially self-stigma, when designing and providing services.

*Eliminate health disparities:* If effective, equitable services are to be provided to all populations, accurate and contextual data must be collected, analyzed and used for the purpose of identifying needs, gaps and available/necessary resources.

*Transform Wisconsin’s public health system:* Wisconsin’s public health system will be transformed if it acknowledges the impact of stigma and discrimination on persons with mental illness and their families with differing and similar needs of various populations. Providers in the system must engage in a sustained dialogue and relationships with stakeholders and leaders of all communities. Managers within the system must analyze data and outcomes in order to review their policies, procedures and protocols. Those within and outside the system must work together to make modification, expansion and/or specific change in order to eliminate stigma and discrimination and to effectively and equitably provide Best Practice treatment and recovery-oriented, culturally competent and stigma-free services to all persons.

**Key Interventions and/or Strategies Planned:**
- Establish a three-module Anti-Discrimination/Anti-Stigma Campaign.
- Create Wisconsin United for Mental Health, a web site, and engage high level, visible spokespersons.
- Pass parity legislation in Wisconsin.
- Promote best practice models throughout Wisconsin.
- Increase capacity of current and future workforce to understand stigma, discrimination, and recovery and be better able to identify and respond to persons with mental disorders.
- Increase the number of state residents who know their rights to mental health services through their health insurance plans.
- Target identified sectors and the general public with campaign materials.
- Develop school-based anti-stigma curriculum modules.
- Develop and launch job development module.
- Create baseline measures.
- Celebrate achievement.
References:


Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Community Mental Health. *FFY Community Mental Health Block Grant: Wisconsin Adult Mental Health State Plan.* p.86-88.

Wisconsin State Statutes, Mental Health Act: s.51.032 Wis. Stats. Revisor of Statutes Bureau. Madison, WI.
APPENDIX A

*Healthy People 2010*, November 2000, United States Department of Health and Human Services, cites the following baseline and target data:

<table>
<thead>
<tr>
<th>Objective: Increase in Adults with Mental Disorders Receiving Treatment</th>
<th>1997 Baseline (unless noted)</th>
<th>2010 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-9a Adults aged 18 to 54 years with serious mental illness</td>
<td>47 (1991)</td>
<td>55</td>
</tr>
<tr>
<td>18-9b Adults aged 18 years and older with recognized depression</td>
<td>23</td>
<td>50</td>
</tr>
<tr>
<td>18-9c Adults aged 18 years and older with schizophrenia</td>
<td>60 (1984)</td>
<td>75</td>
</tr>
<tr>
<td>18-9d Adults aged 18 years and older with generalized anxiety disorder</td>
<td>38</td>
<td>50</td>
</tr>
</tbody>
</table>
### Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2

## Long-term (2010) Subcommittee Outcome Objective:

2a: By 2010, an additional 15 percent of the general public will demonstrate an understanding that individuals with mental health disorders can recover through treatment to lead productive, healthy, and happy lives.

2b: By 2010, an additional 15 percent of the general public will demonstrate the belief that individuals with mental health disorders are capable of sustaining long-term productive employment.

Long-term outcome objective updated as of: Sept 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental illness: Wisconsin United for Mental Health, a coalition of stakeholders directing a sustained, multi-faceted anti-stigma initiative. Directed efforts of consumers will become trained advocates and leaders. Families: Families, with members who have mental illness will continue to advocate through training and support to change and decrease stigma toward their family members. Faith Communities: Leaders of faith communities participate to increase</td>
<td>Acknowledgement of the Issue of Discrimination The first step in solving a problem is acknowledging that it exists. While discrimination is an all too real problem for persons with mental illness, unfortunately it is not necessarily perceived with any urgency by the general population. The first short-term outcome is to identify an existing survey, or to conduct a Wisconsin survey, or opinion poll to establish base-line data to indicate the public’s perception of the issues of discrimination and stigma (including self-stigma reinforced by negative stereotypes of mental illness). The survey will address the public’s understanding that the messages transmitted by the media don’t indicate the “whole truth” about the wide range of persons with mental illness and the public’s understanding that mentally ill persons do make positive contributions to society.</td>
<td>Refer to “Inputs” section for a description of partners.</td>
<td>By the year 2002: The “Anti-Discrimination/Anti-Stigma” Campaign (materials and 3 Modules Training curricula with a Strategic Plan) is initiated; key consumer/family spokespersons are identified. The Steering Committee adopts the name “Wisconsin United for Mental Health” and announces Web Site: <a href="http://www.wi.mentalhealth.org">www.wi.mentalhealth.org</a>. An existing survey is identified or a Wisconsin survey or opinion poll is conducted to establish base-line data.</td>
<td>By the year 2005: Increase the number of state residents who are knowledgeable regarding their right to mental health services through their insurance companies. Increase the number of state residents who have an understanding that persons with mental illness are fully capable of making meaningful positive contributions to society, do recover, and experience stigma and discrimination. Increase the number of factual, accurate reporting and media portrayal of persons with mental illness as</td>
<td>By the year 2008: Eighty percent of identified audiences will have received or been “reached” with “anti-stigma” materials and will have been provided the opportunity to participate in a variety of training opportunities. Implement legislation to provide resources and policies to increase employment opportunities for persons with mental illness, define employment guidelines for workplace accommodation, and strengthen anti-discrimination legislation.</td>
</tr>
<tr>
<td>Inputs</td>
<td>Create and Launch an Initial Anti-Stigma/Anti-Discrimination Campaign with Stakeholders/Key Leaders</td>
<td>Parity legislation passed in Wisconsin.</td>
<td>measured through public reporting, through survey.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another short-term goal is ensuring that key leaders and opinion-shapers utilize key anti-stigma communication strategies and materials. The goal is to increase the role of community leaders in communicating positive and accurate messages about persons with mental illness, which emphasize their recovery, success and positive contributions.</td>
<td>Identify key leaders, high profile media figures, political and community leaders who understand the issues are identified and participate as spokespersons for Wisconsin United for Mental Health Initiative.</td>
<td>Increase the number of insured individuals receiving medically necessary mental healthcare.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools/Educators: Schools will become a clearinghouse to expose students to a caring, fact-based explanation of mental illness, innovative treatment, and successful recovery by persons with mental illness.</td>
<td>By the year 2003: Initiative begins in selected Wisconsin communities, media markets, other audiences, and business.</td>
<td>By the year 2006: A measured decrease in stigma is attained, based upon standard polling through survey tools created for each targeted group of providers and other system partners including consumer report.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law Enforcement: More comprehensive information, a more positive approach, and better training will enable law enforcement professionals in a variety of settings to ensure the well-being of individuals with mental illness, approach them</td>
<td>By the year 2004: Increase, as measured by standard polling, in the percentage of the population that understands the existence of discrimination and stigma (including self-stigma).</td>
<td>By the year 2007: Add training opportunities for non-mental health specialists to enhance their mental health knowledge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2</td>
<td>Develop a “Three Module” Anti-Stigma/Anti-Discrimination Campaign</td>
<td>Identify outcome measurements for improvement of stigma and discrimination reduction for persons with mental illness and for all other targeted groups.</td>
<td>Increase and measure outcomes through evaluation that identifies at least 75 percent of mental health consumers reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inputs</td>
<td>Outputs</td>
<td>Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>more positively, and more effectively direct them towards appropriate treatment.</td>
<td>Activities: target audiences with specific messages. The modules affect access to treatment, the recovery process, and reducing stigma.</td>
</tr>
</tbody>
</table>
| Emergency Room Personnel: The initiative should result in improved emergency room personnel to make effective initial treatment and treatment by referral decisions. | Promote Best Practice Models
Wisconsin will take steps to identify Best Practice standards and models. An Assessment of Needs tool for providers will be developed to determine current capacity to provide Best Practice mental health services and identification of challenges and opportunities to be a Best Practice delivery system. Collaboration between stakeholders and consumers/families in identifying and sharing of materials will assist in developing and maintaining their capacity to serve persons with mental illness from all communities. Best practice models in use by providers, consumers, or families, along with input from all other stakeholders and researched best practice mental health services, will be recognized. |
| Crisis Response Teams: More comprehensive information, a more positive approach, and better training will enable crisis response professionals in a variety of settings to ensure the well-being of persons with mental illness, approach them more positively, and more effectively direct to appropriate treatment. | Develop Targeted Anti-Stigma Education/Communications Modules
Wisconsin will develop or obtain varied anti-stigma education, awareness, and communications materials to address targeted audiences in the “three module interactive” strategy. These materials will: (a) provide unique anti-stigma “take-away messages” to target audiences; (b) provide action steps or strategies that community or targeted group members can act upon; and (c) generate supportive public |

**Health Priority: Mental Health and Mental Disorders**  
**Objective 2: Discrimination/Anti-Stigma (Logic Model)**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>more positively, and more effectively direct them towards appropriate treatment.</td>
<td>Activities: target audiences with specific messages. The modules affect access to treatment, the recovery process, and reducing stigma.</td>
</tr>
</tbody>
</table>
| Emergency Room Personnel: The initiative should result in improved emergency room personnel to make effective initial treatment and treatment by referral decisions. | Promote Best Practice Models
Wisconsin will take steps to identify Best Practice standards and models. An Assessment of Needs tool for providers will be developed to determine current capacity to provide Best Practice mental health services and identification of challenges and opportunities to be a Best Practice delivery system. Collaboration between stakeholders and consumers/families in identifying and sharing of materials will assist in developing and maintaining their capacity to serve persons with mental illness from all communities. Best practice models in use by providers, consumers, or families, along with input from all other stakeholders and researched best practice mental health services, will be recognized. |
| Crisis Response Teams: More comprehensive information, a more positive approach, and better training will enable crisis response professionals in a variety of settings to ensure the well-being of persons with mental illness, approach them more positively, and more effectively direct to appropriate treatment. | Develop Targeted Anti-Stigma Education/Communications Modules
Wisconsin will develop or obtain varied anti-stigma education, awareness, and communications materials to address targeted audiences in the “three module interactive” strategy. These materials will: (a) provide unique anti-stigma “take-away messages” to target audiences; (b) provide action steps or strategies that community or targeted group members can act upon; and (c) generate supportive public |

**Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>more positively, and more effectively direct them towards appropriate treatment.</td>
<td>target audiences with specific messages. The modules affect access to treatment, the recovery process, and reducing stigma.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Emergency Room Personnel: The initiative should result in improved emergency room personnel to make effective initial treatment and treatment by referral decisions. | Promote Best Practice Models
Wisconsin will take steps to identify Best Practice standards and models. An Assessment of Needs tool for providers will be developed to determine current capacity to provide Best Practice mental health services and identification of challenges and opportunities to be a Best Practice delivery system. Collaboration between stakeholders and consumers/families in identifying and sharing of materials will assist in developing and maintaining their capacity to serve persons with mental illness from all communities. Best practice models in use by providers, consumers, or families, along with input from all other stakeholders and researched best practice mental health services, will be recognized. | | | | |
| Crisis Response Teams: More comprehensive information, a more positive approach, and better training will enable crisis response professionals in a variety of settings to ensure the well-being of persons with mental illness, approach them more positively, and more effectively direct to appropriate treatment. | Develop Targeted Anti-Stigma Education/Communications Modules
Wisconsin will develop or obtain varied anti-stigma education, awareness, and communications materials to address targeted audiences in the “three module interactive” strategy. These materials will: (a) provide unique anti-stigma “take-away messages” to target audiences; (b) provide action steps or strategies that community or targeted group members can act upon; and (c) generate supportive public | | | | |

that they have benefited from targeted campaigns to address and overcome self-stigma.  
Increase and measure outcomes through evaluation that identifies 100 percent of identified audiences have received “anti-stigma” materials and have been provided the opportunity to participate in a variety of training opportunities.  
Reduce by 10 percent the proportion of the population that reports difficulties in, delays in, or the inability to receive “best practice” mental health treatment.  
Improve outcomes for persons with mental illness achieved through evaluation based on outcome measurements.  
Increase by 10 percent the number of people with a mental health need to have timely access to evidence-based treatment.
### Health Priority: Mental Health and Mental Disorders

**Objective 2: Discrimination/Anti-Stigma (Logic Model)**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Activities</strong></td>
</tr>
</tbody>
</table>
| persons with mental illness while providing them with effective ways to refer individuals to appropriate services | communication from key members of each target audience segment.  
*Develop School-Based Anti-Stigma Curriculum Models.* The short-term objective for this initiative will be to provide schools with models for identifying and assessing mental illness and responding effectively in making appropriate diagnoses and providing appropriate services and referrals. There is an immediate need to develop successful strategies within Wisconsin’s schools and higher educational settings to address discrimination and stigma associated with mental illness and to increase students’ understanding of mental illness and recovery. Additionally, there is a need to appropriately train educators and student peer groups to identify at-risk students as well as students with emotional problems. Curriculum units will be developed to address and identify discrimination and stigma. Currently, a disproportionate number of multi-ethnic/multi-racial children are represented in special education classes.  
*Develop and Launch a Job Development Module*  
There are proven and effective strategies that public mental health agencies can promote and use within communities to increase the number of mental health consumers who successfully obtain long-term employment. Business partners and | | | | Improve outcomes for persons with mental illness achieved through evaluation based on outcome measurements. | Improve outcomes achieved through evaluation based on measuring stigma among the general public based on survey tools created for each targeted group within the general public. |
| Mental Health Providers: Among the materials included in the Initiative are materials that emphasize recovery and educate mental health providers about discrimination, stigma and self-stigma encountered by persons with mental illness. | | | | | |
| Employee Assistance Program (EAP) Managers/Benefits Managers: These materials will ensure benefits managers understand/change policies and procedures to ensure work environments provide reasonable and accessible accommodation for persons with mental illness and that | | | | | |
**Health Priority: Mental Health and Mental Disorders**  
**Objective 2: Discrimination/Anti-Stigma (Logic Model)**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Participation/Reach</strong></td>
</tr>
<tr>
<td>insurance plans cover medications and mental health treatment.</td>
<td>extending into medium-term outcomes, the initiative will seek to achieve a variety of outcomes including measured changes in public perceptions/opinions.</td>
</tr>
<tr>
<td><strong>Corporations:</strong> To provide jobs, to offer positive opportunities for persons with mental illness, and provide flexible hours and work environment accommodations for all to overcome both institutional stigma and self-stigma. Corporations can play an important and effective role in fighting stigma and discrimination.</td>
<td>• There will be a significant percentage point increase in Wisconsin residents who indicate that they believe that persons with mental illness can be successfully employed, live in their community and recover. • Among individuals who play a prominent role in helping persons with mental illness enter into formal treatment regimens:</td>
</tr>
<tr>
<td><strong>Psychiatrists/Psychologists:</strong> Exposure to effective treatment methods will help providers emphasize recovery-oriented research and evidence-based treatment models.</td>
<td>• One hundred percent of law enforcement personnel in Wisconsin will be offered the opportunity to participate in training programs that presents factual and accurate information about mental illness and recovery, provides crisis intervention training on effective interaction with persons with a mental illness, and provides access into appropriate treatment.</td>
</tr>
<tr>
<td><strong>Landlords:</strong> Important materials developed to impact and to increase the cooperation of landlords to</td>
<td>• One hundred percent of emergency room staff in Wisconsin will be offered the opportunity to participate in training programs that helps them effectively recognize, screen, and assess mental illness disorders, and refer persons with mental illness into appropriate and accessible treatment settings. • One hundred percent of healthcare and mental healthcare professionals licensed</td>
</tr>
</tbody>
</table>

Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2
### Health Priority: Mental Health and Mental Disorders

#### Objective 2: Discrimination/Anti-Stigma (Logic Model)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>make available increased safe, affordable housing units to persons with mental illness.</td>
<td>to practice in Wisconsin will be offered the opportunity to participate in training to recognize that (1) stigma occurs within the mental health system and the broader healthcare system, and (2) that the effects of self-stigma for consumers may be due to treatment services received, providers’ attitudes, and the stigma associated with the label and diagnosis of mental illness in individuals of all ages. One hundred percent of the healthcare professionals in Wisconsin will be offered the opportunity to participate in learning how to identify and refer patients to appropriate mental healthcare services with information on mental health screening tools or questions for early identification of mental health problems across the life span. • One hundred percent of mental health professionals licensed in Wisconsin will be offered the opportunity to participate in recovery-oriented and anti-stigma training. and refer patients to appropriate mental healthcare services with information on mental health screening tools or questions for early identification of mental health problems across the life span. • One hundred percent of mental health professionals licensed in Wisconsin will be offered the opportunity to participate in recovery-oriented and anti-stigma training.</td>
<td>Participation/Reach</td>
</tr>
<tr>
<td>Media/Entertainment/Advertising Figures: Media, entertainment, and advertising figures participate with an essential role in communicating positive, factual messages about mental illness and the positive contributions of persons with mental illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political Leaders: Wisconsin United for Mental Health will work to create bipartisan support in the fight against discrimination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Government Agencies: State agencies lead the fight against discrimination, they can lead by example through hiring increasing numbers of</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 2
### Health Priority: Mental Health and Mental Disorders

**Objective 2: Discrimination/Anti-Stigma (Logic Model)**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Activities</strong></td>
</tr>
<tr>
<td>persons with mental illness.</td>
<td>One hundred percent of the psychiatrists/psychologists practicing in Wisconsin will be offered the opportunity to participate in training that is recovery-oriented and addresses self-stigma of consumers, along with stigma occurring within the mental health system, reviews Best Practice and utilization of new and emerging pharmacological/therapeutic treatments. This training may include evidence-based approaches, which promote research into Best Practice of clinically sound approaches to successful treatment of persons with mental illness.</td>
</tr>
<tr>
<td><strong>Political Leaders:</strong> Wisconsin United for Mental Health will work to create bi-partisan support in the fight against discrimination.</td>
<td></td>
</tr>
<tr>
<td><strong>State Government Agencies:</strong> State agencies lead the fight against discrimination, they can lead by example through hiring increasing numbers of persons with mental illness.</td>
<td></td>
</tr>
<tr>
<td><strong>Cultural Leaders:</strong> Leaders of all racial, ethnic groups participate to disseminate anti-stigma information, while leading efforts to bring more effective treatment methods to persons</td>
<td></td>
</tr>
<tr>
<td><strong>Cultural Leaders:</strong> Leaders of all racial, ethnic groups participate to</td>
<td></td>
</tr>
</tbody>
</table>

- One hundred percent of landlords and management companies in Wisconsin with more than 100 rental units will receive anti-stigma materials illustrating successful recovery stories of persons with mental illness. These materials will include specific information on housing-based subsidy/guarantee programs for individuals with low incomes and the potential for these individuals to be successful tenants.

- One hundred percent of Employee Assistance Program (EAP) managers or benefits managers for corporations with more than 100 employees in Wisconsin will receive materials about (1) discrimination against persons with mental illness and information about the positive roles corporations can play in helping persons with mental illness successfully recover, and (2) strategies for
**Health Priority: Mental Health and Mental Disorders**  
**Objective 2: Discrimination/Anti-Stigma (Logic Model)**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
</table>
| disseminate anti-stigma information, while leading efforts to bring more effective treatment methods to persons with mental illness within their cultural groups. | providing accommodations in the workplace for persons with mental illness, and the promotion of understanding mental illness among employees. Among individuals who may play a prominent role in reducing stigma and discrimination while improving the general public’s perception of persons with mental illness:  
- One hundred percent of television and radio stations located in Wisconsin will be provided with public service announcements that address the issue of discrimination and stigma.  
- One hundred percent of the leaders of the executive and legislative branches of state government will be offered the opportunity to contribute footage to the various anti-stigma videos or other media materials produced for different target audiences.  
- All state agencies will institute specific employment guidelines describing the issue of discrimination/anti-stigma and detailing how accommodations shall be provided to persons with mental illness and what constitutes harassment toward persons with mental illness in the workplace. Education materials for all state employees will accompany the programs on recovery, workplace accommodation, and the positive and successful contributions made by persons with mental illness. | | | |
<p>| Judges/Lawyers: Judges and lawyers who are the first line of the criminal justice system will play an increasingly important role in helping persons with mental illness gain entry into appropriate treatment programs to provide jail diversion. | | | | |
| Stakeholder Corporations: Pharmaceutical companies and others will play a catalytic role to create and disseminate factual information on mental illness, and recovery. | | | | |
| Training: The anti-stigma initiative will promote a broad spectrum of training opportunities across a | | | | |</p>
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Participation/Reach</strong></td>
</tr>
<tr>
<td>multitude of professions.</td>
<td>• One hundred percent of educators at all levels in Wisconsin will receive curriculum materials on educating students with the facts about mental illness along with suicide prevention, early identification and referral to appropriate treatment for students, and suggested strategies to eliminate discrimination and stigma against persons with mental illness.</td>
</tr>
<tr>
<td>Funding: The State and other external partners may provide both funding and resources.</td>
<td>• One hundred percent of religious leaders will receive materials on how they can help counsel persons with mental illness, and how they can refer persons with mental illness for appropriate treatment. These materials will also include materials to help members of their congregations recognize and overcome stigma and discrimination.</td>
</tr>
<tr>
<td>Materials: A variety of printed, video and online materials will be developed.</td>
<td>• One hundred percent of the leaders of recognized community/cultural organizations will receive materials on discrimination and stigma.</td>
</tr>
</tbody>
</table>
| Media: Various media contacts and partnerships formed and “messages” developed. | *Create Baseline Measures*
At the same time public and private state and county mental health agencies, advocates, persons with mental illness and their families meet outcomes cited above, the Department of Health and Family Services may develop baseline measures to collect data on “achievement outcomes” (concrete results achieved). | | | |
### Health Priority: Mental Health and Mental Disorders
### Objective 2: Discrimination/Anti-Stigma (Logic Model)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coordinated Stakeholder Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In many cases, individual stakeholders will have to come together in coordinated outreach efforts. For example, law enforcement officials and lawyers can work together to increase the number of persons with mental illness who are promptly referred to appropriate treatment alternatives rather than incarcerated. Similarly, employers and landlords can work together to make sure that persons with mental illness with effective treatment regimens have employment and housing opportunities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Health Coordination and Collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The biggest contribution public health will play will be in coordinating the many stakeholders involved in this effort to create and sustain a positive momentum in fighting stigma and discrimination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Celebrate Achievement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This effort should recognize and celebrate achievement. This recognition of achievement will occur on two levels: 1) the celebration of individuals who successfully recover and once again make a sustained, positive contribution to society; and 2) the celebration of key “achievement goals.”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Health Priority: Mental Health and Mental Disorders

**Objective 3: Cultural Competence (Logic Model)**

**Long-term (2010) Subcommittee Outcome Objective:** By 2010, 87 percent of publicly funded mental health consumers will feel their service provider was sensitive to their culture during the treatment planning and delivery process.

Long-term outcome objective updated as of: Sept 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health consumers and family members</td>
<td>Develop a Self-Assessment of Needs Tool Determine present capacity of providers to provide culturally competent services and determine challenges and opportunities to become a “best practice” delivery system. This assessment tool will be designed to gather statistical data and necessary information to assist providers in looking at their current internal service capacity regarding:</td>
<td>Individuals with mental illness Families Faith/spiritual communities Healthcare providers Mental health agencies Mental health professionals Media/community natural/appointed leaders Local health departments Schools</td>
<td>By 2002, a self-evaluation tool will be developed with the input of key stakeholders. By 2003, outreach strategies to reach special populations will have been identified and the information shared with systems/stakeholders using various approaches and formats. By 2004, develop an interim status report to identify specific accomplishments, challenges, and opportunities for implementation of Phase II, Medium Term. By 2004, begin a random review of the information and data gathered through systems/stakeholders evaluations, mental health surveys, and other relevant avenues to determine the</td>
<td>By 2005, identify and provide systems and stakeholders with available tools, strategies, and resources to assist them in delivering effective culturally competent services. By 2006, recommend effective legislation, policies, and procedures are implemented in response to identified challenges to the provision of effective culturally competent services. By 2008, develop integrated systems and procedures for ongoing monitoring and evaluation of systems/stakeholders regarding the provision of effective delivery services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural and tribal leaders/community leaders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minority media and entertainment figures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated state staff to guide and develop the process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder corporations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local health departments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faith and spiritual communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment of time and fiscal support of existing staff and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Logic Model – Health Priority: Mental Health and Mental Disorders – Objective 3
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>experts to develop materials and develop and carry out trainings</td>
<td>short-, medium-, and long-term goals.</td>
<td>capacity of systems and stakeholders to provide effective cross-cultural services.</td>
<td>to effectively address the mental health needs of targeted populations through relevant cultural variables that promote and positively affect the equitable, fair and inclusive provision of culturally competent services.</td>
</tr>
<tr>
<td>Distance learning technologies to communicate with distant partners including mental health consumers, families, representatives from diverse groups</td>
<td>Promote a Greater Awareness Regarding Available Services in Targeted Minority and Other Communities: Develop and implement outreach strategies to inform targeted groups of available mental health services, dispel myths and assumptions, and provide them with information regarding preventive and early intervention strategies to ensure good health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time and energy of all partners</td>
<td>Identify Existent Materials/Technical Assistance: Collaborate with appropriate stakeholders and community leaders in identifying and sharing materials that will assist providers to create and/or maintain the capacity to offer culturally competent care to the communities they serve.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified culturally competent materials and training curriculum</td>
<td>Identify Best Practice Models: Recognize providers and other stakeholders among systems that excel in the provision of culturally competent and effective services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Research and Identify Cost-Effective and Useful Ways to Provide Information and Training/Technical Assistance to Providers and Other Stakeholders: Collaborate with stakeholders, such as primary healthcare, social services, and state-level departments and divisions across service systems to explore training/technical assistance models which may result in culturally competent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Health Priority: Mental Health and Mental Disorders
### Objective 3: Cultural Competence (Logic Model)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Identify and Secure Materials: Surveys, technical assistance manuals, guidelines and other related resources are promoted that can assist systems/stakeholders to identify and address individual/group variables which may have impact in the quality of services to all mental health consumers. These variables may include language, race, ethnicity, natural origin, disability, age, gender, religion, sexual orientation, and others.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Devise Simple, Standardized Assessment Instruments and Clinical Protocols: To enable English-speaking mental health professionals in determining the potential needs and issues of people without English proficiency in a way that respects their belief systems and allows for the use of an interpreter when necessary.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assist Systems and Stakeholders: In identifying and working with culturally competent individuals (trained mental health consumers, family members, as well as community leaders) who could act as “bridge builders” between systems and diverse groups to “market” and promote acceptance of mental health treatment in their communities that is delivered with respect and in a culturally sensitive manner.</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish Service Outcome Evaluation Criteria and Create Culturally and Linguistically Appropriate Mental Health Satisfaction Surveys: To be completed by mental health consumers and designed to provide the service system with feedback on its efforts to provide culturally competent care.</td>
<td></td>
</tr>
</tbody>
</table>

**Assist Providers in the Development and Implementation of Recruitment, Hiring and Succession Plans:** To ensure appropriate employee representation of people of cultural/ethnic groups at all levels of the service delivery system.
Health Priority: Mental Health and Mental Disorders
Objective 3: Cultural Competence (Template)

Long-Term (2010) Subcommittee Outcome Objective:
By 2010, 87 percent of publicly funded mental health consumers will feel their service provider was sensitive to their culture during the treatment planning and delivery process.

This will be accomplished through a collaborative process of stakeholders such as providers and advocacy groups representing potential and actual consumers.

Achieving this 10-year outcome objective will contribute to the shared vision of the public health system of healthy people in healthy Wisconsin communities as demonstrated in (a) a more healthy Wisconsin population, (b) a more productive population, (c) reduced suicides across the life span, and (d) improved family relationships.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of respondents who report they &quot;Agree&quot; or &quot;Strongly Agree&quot; with the following statement about their mental health treatment. A score of 2.00 or lower will represent a positive response about the culturally competent manner in which services were delivered.</td>
<td></td>
</tr>
<tr>
<td>&quot;Staff were sensitive to my cultural background (race, religion, language, etc.)&quot;</td>
<td></td>
</tr>
<tr>
<td>Baseline measure in 2003 revealed 77 percent of consumers had a positive response.</td>
<td>The Mental Health Statistical Improvement Program's Consumer Satisfaction Survey was implemented in 2003 for the first time. The survey is currently administered to a random sample of mental health consumers in Wisconsin, but an oversampling of minority populations may be necessary in future years because they were inadvertently undersampled in 2003.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, this is a developmental objective.</td>
<td><strong>Healthy People 2010</strong>, November 2000, United States Department of Health and Human Services, cites the following potential data sources for this developmental objective: National Technical Assistance Center for State Mental Health Systems; National Association of State Mental Health Program Directors; National Research Institute; Substance Abuse and Mental Health Services Administration; and Center for Mental Health Services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – Mental Health and Mental Disorders</td>
<td>Improve mental health and ensure access to appropriate, quality mental health services.</td>
<td>18-13</td>
<td>(Developmental) Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer</td>
<td>A person of any age, who has received or currently is receiving mental health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>The shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people that are unified by factors that may include race, ethnicity, language, nationality or religion, sexual orientation, and/or other individual/collective factors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural competence*</td>
<td>Having the ability to function effectively as an individual and as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Department of Health and Family Services, Division of Public Health).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A set of skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from a community (Department of Health and Family Services, Division of Supportive Living).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural groups</td>
<td>A group of people who consciously or unconsciously share identifiable values, norms, symbols, and traditions that are repeated and transmitted from one generation to another.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural diversity</td>
<td>Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A community is said to be culturally diverse if its residents include members of different groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural awareness</td>
<td>An awareness of the nuances of one’s own and other cultures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic</td>
<td>Belonging to a common group often linked by race, nationality, and language with common cultural heritage and/or derivation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>The form or pattern of speech which is spoken or written, used by residents or descendants of a particular nation or geographic area or by any large body of people. Language can be formal or informal and includes American Sign Language, Signed English, dialect, idiomatic speech, and slang.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multicultural</td>
<td>Designed for or pertaining to two or more distinctive cultures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>As defined by the Americans with Disabilities Act, refers to a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment. The Americans with Disabilities Act does not specifically name all of the impairments that are covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening tool</td>
<td>Those instruments and techniques (e.g., questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>The process of assisting an individual to obtain services from a health professional who can assess and treat, if necessary, a suspected health condition.</td>
</tr>
<tr>
<td>Assessment</td>
<td>The process used to evaluate an individual’s present problems with an accompanying description of the reported or observed conditions which led to the classification or diagnosis of the individual’s illness.</td>
</tr>
<tr>
<td>Partner systems</td>
<td>Service systems combining to work on increased screening in order to improve identification and referral of individuals who may be experiencing mental disorders. These include education, corrections, healthcare, social services, aging, childcare, and early childhood.</td>
</tr>
</tbody>
</table>

### Rationale

- Title VI of the Federal Civil Rights Act and Limited English Proficiency guidelines requires the provision of services in the language of the client and in a culturally competent manner.
- The Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 requires the provision of effective services to applicants/clients who have disabilities.
- The Wisconsin Department of Health and Family services and other partners/stakeholders are committed to ensuring that all individuals are treated fairly and are not discriminated against based on sexual orientation, religion, age and other invalid factors.
- According to the 1990-1999 U.S. Census, Wisconsin population reflects an increase of 15 percent for African Americans, 30 percent for Hispanic Latino, and 32 percent for Asian Pacific Islander. These percentages are expected to continue to increase in the next 10 years.
- The utilization of mental health services is far higher among affluent white individuals than any other socioeconomic and ethnic group. In part, this reflects a societal reality that all health services are more completely utilized by affluent whites than any other group.
- Mental health professionals who work with different cultural groups cite three reasons for the lack of utilization of mental health services by minority groups:
  1. Mental health providers are not able to speak the person’s language.
  2. Cultural norms among the minority group may mitigate against the utilization of mental health services as they are currently offered.
  3. Mental health services are not presented in a culturally sensitive manner nor are they easily accessible by members of many minority cultures.
- In the Executive Summary of the Report of the Surgeon General entitled *Mental Health: Culture, Race, and Ethnicity*, the Surgeon General made this single, explicit recommendation for all people to “Seek help if you have a mental health problem or think you have symptoms of a mental disorder” (U.S. Department of Health and Human Services, 2001). The following highlights from this report provide a compelling call to understanding and action:
  - Seeking help is particularly vital, considering the majority of people with diagnosable disorders, regardless of race or ethnicity, do not receive treatment. The stigma surrounding mental illness is a powerful barrier to reaching treatment. Persons with mental illness feel shame and fear of discrimination about a condition that is as real and disabling as any other serious health condition.
  - All Americans do not share equally in the hope for recovery from mental illness:
“Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”

“This Supplement was undertaken to probe more deeply into mental health disparities affecting racial and ethnic minorities. Drawing on scientific evidence from a wide-ranging body of empirical research, this Supplement has three purposes:
1. To understand better the nature and extent of mental health disparities;
2. To present the evidence on the need for mental health services and the provision of services to meet those needs; and
3. To document promising directions toward the elimination of mental health disparities and the promotion of mental health.”

As stated in the mental chapter of Healthy People 2010 “. . . to work effectively, healthcare providers need to understand the differences in how various populations in the United States perceive mental health and mental illness and treatment services. These factors affect whether people seek mental healthcare, how they describe their symptoms, the duration of care, and the outcomes of the care received. Research has shown that various select populations use mental health services differently. They may not seek mental health services in the formal system, drop out of care, or seek care at much later stages of illness, driving the service cost higher. This pattern of use appears to be the result of a community-based mental health service system that is not culturally relevant, responsive, or accessible to select populations. Hospitals have become the primary mental health treatment site for a disproportionate number of African Americans (United States Department of Health and Human Services, 2000).

Both the general public in Wisconsin and the community of mental health professionals must move from increasing awareness to commitment and competency:
- Although there are cultural competency materials available for insight and guidance, there is a need to identify those materials that are pertinent to mental health and are useful to professional practitioners.
- There is evidence that the utilization of mental health services among different ethnic/cultural groups varies dramatically; no minority group approaches the utilization percentage of middle class and affluent whites.
- Mental health services offered do not always reflect the cultural and religious values and beliefs of the individuals served. Mental health professionals have found this to be true especially among Native American Tribes, Southeast Asian, and Hmong cultures.
- Wisconsin needs to have a workforce of adequately trained and skilled individuals of sufficiency to deliver the right types of services, in an appropriate way, to all individuals.

**Outcomes:**

**Short-term Outcome Objectives (2002-2004)**
- By 2002, a self-evaluation tool will be developed with the input of key stakeholders.
- By 2003, outreach strategies to reach special populations will have been identified and the information shared with systems/stakeholders using various approaches and formats.
- By 2003, identify best practices models and provide recognition to those systems and stakeholders which have shown excellence in providing culturally competent services.
• By 2004, develop an interim status report to identify specific accomplishments, challenges, and opportunities for implementation of Phase II, Medium Term.
• By 2004, begin a random review of the information and data gathered through systems/stakeholders evaluations, mental health surveys, and other relevant avenues to determine the capacity of systems and stakeholders to provide effective cross-cultural services.

**Medium-term Outcome Objectives (2005-2007)**

• By 2005, identify and provide systems and stakeholders with available tools, strategies, and resources to assist them in delivering effective culturally competent services.
• By 2006, recommend effective legislation, policies, and procedures are implemented in response to identified challenges to the provision of effective culturally competent services.

**Long-term Outcome Objectives (2008-2010)**

• By 2008, develop integrated systems and procedures for ongoing monitoring and evaluation of systems/stakeholders regarding the provision of effective delivery services.
• By 2009, identify and share evaluation reports and outcomes with other systems and stakeholders including the state to promote best practice models, innovative outreach and information strategies, effective data collection, analysis systems with successful uses of data for research, program development, measured outcomes, and strategic implementation. Acknowledge publicly through the media, positive and constructive developments from the data.
• By 2010, a measured increase in capacity by all systems and stakeholders to effectively address the mental health needs of targeted populations through relevant cultural variables that promote and positively affect the equitable, fair and inclusive provision of culturally competent services.

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

- Mental health consumers and family members
- Cultural and tribal leaders/community leaders
- Minority media and entertainment figures
- Designated state staff to guide and develop the process
- Stakeholder corporations
- Local health departments
- Schools
- Faith and spiritual communities
- Investment of time and fiscal support of existing staff and experts to develop materials and develop and carry out trainings
- Distance learning technologies to communicate with distant partners including mental health consumers, families, representatives from diverse groups
- Time and energy of all partners
- Identified culturally competent materials and training curriculum

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach - community residents, agencies, organizations, elected officials, policy leaders, etc.)*
Activities:

**Develop a Self-Assessment of Needs Tool**
Determine present capacity of providers to provide culturally competent services and determine challenges and opportunities to become a “best practice” delivery system. This assessment tool will be designed to gather statistical data and necessary information to assist providers in looking at their current internal service capacity regarding:

- Cultural groups that are presently under-utilizing mental health services in relationship to the majority population;
- The number of mental health professionals in facilities and/or organizations who are representative of targeted groups and are providing services to persons in these groups as well as others;
- Determination of the gap between the unmet needs for appropriate mental health services and the current capacity of professionals within their systems to provide these services;
- Collection and analysis of available data and other related material and information regarding access and availability of services for targeted populations. Utilize the results of the analysis to develop baseline data and benchmarks to be used to evaluate results of implementation activities or action steps taken to meet the short-, medium-, and long-term goals.

**Promote a Greater Awareness Regarding Available Services in Targeted Minority and Other Communities:** Develop and implement outreach strategies to inform targeted groups of available mental health services, dispel myths and assumptions, and provide them with information regarding preventive and early intervention strategies to ensure good health.

- **Identify Existent Materials/Technical Assistance:** Collaborate with appropriate stakeholders and community leaders in identifying and sharing materials that will assist providers to create and/or maintain the capacity to offer culturally competent care to the communities they serve.
- **Identify Best Practice Models:** Recognize providers and other stakeholders among systems that excel in the provision of culturally competent and effective services.
- **Research and Identify Cost-Effective and Useful Ways to Provide Information and Training/Technical Assistance to Providers and Other Stakeholders:** Collaborate with stakeholders, such as primary healthcare, social services, and state-level departments and divisions across service systems to explore training/technical assistance models which may result in culturally competent training/technical assistance being available in a cost-effective manner.
- **Identify and Secure Materials:** Surveys, technical assistance manuals, guidelines and other related resources are promoted that can assist systems/stakeholders to identify and address individual/group variables which may have impact in the quality of services to all mental health consumers. These variables may include language, race, ethnicity, natural origin, disability, age, gender, religion, sexual orientation, and others.
Devise Simple, Standardized Assessment Instruments and Clinical Protocols: To enable English-speaking mental health professionals in determining the potential needs and issues of people without English proficiency in a way that respects their belief systems and allows for the use of an interpreter when necessary.

Assist Systems and Stakeholders: In identifying and working with culturally competent individuals (trained mental health consumers, family members, as well as community leaders) who could act as “bridge builders” between systems and diverse groups to “market” and promote acceptance of mental health treatment in their communities that is delivered with respect and in a culturally sensitive manner.

Establish Service Outcome Evaluation Criteria and Create Culturally and Linguistically Appropriate Mental Health Satisfaction Surveys: To be completed by mental health consumers and designed to provide the service system with feedback on its efforts to provide culturally competent care.

Assist Providers in the Development and Implementation of Recruitment, Hiring and Succession Plans: To ensure appropriate employee representation of people of cultural/ethnic groups at all levels of the service delivery system.

Participation/Reach:
The following is a sample of the important contributions made by some of the partners identified on the logic model. These partners include but are not limited to:

- **Individuals with Mental Illness:** This effort will directly involve mental health consumers of all ages from a wide variety of cultural and ethnic groups by enabling them to become advocates for themselves, their family members, and their communities.

- **Families:** Families of individuals with mental illness will provide critical input to ensure that there is appropriate access to appropriate services.

- **Faith/Spiritual Communities:** The leaders of faith and spiritual communities will be among the “bridge builders” (identified community leaders) to help identify the needs of their community members and help promote access to appropriate services.

- **Healthcare Providers:** Healthcare providers will play an important role by referring members of cultural/ethnic groups to appropriate mental health services. Such providers include but are not limited to: physicians, dentists, dental hygienists, nurses, advance practice nurses, social workers, and counselors.

- **Mental Health Agencies:** Mental health agencies will need to allocate time and resources to increase the number of qualified staff members capable of providing appropriate services to targeted cultural/ethnic groups.

- **Mental Health Professionals:** Mental health professionals of all types will need to initiate a substantial, broad-based effort to determine service gaps and needs, develop appropriate materials, train their peers, and implement these new materials in a caring and respectful manner.

- **Media/Community Natural/Appointed Leaders:** High profile people (key community leaders) of cultural/ethnic groups will lend their support to this initiative in order to increase awareness among the targeted populations.

- **Local Health Departments:** Local health departments because of their increasingly large reach into the community are critical mental health partners in both traditional and new nontraditional settings. Local boards of health can work with other county
and municipal policy boards and create synergy for sound policy. Local epidemiologists are in key positions to collect and analyze data to inform policy, program, action, and evaluation. Public health nurses, public health educators, public health nutritionists, and environmental specialists will help to determine current and emerging gaps in service and are key people in modeling and carrying the message of cultural competence throughout the community.

- **Schools:** Local schools play a primary role in creating resilient environments for children, families, and staff. Teachers, school nurses, pupil services teams, principals, and administrators because of their front-line contact with children, adolescents, and families are in key positions to identify individuals and families at-risk; serve as strong advocates; and provide a community “safety-net.” They, like local health departments, are key people in modeling and carrying the message of cultural competency throughout the community.

### Evaluation and Measurement

Begin an evaluation of cross systems/stakeholders’ that will determine system capacity for provision of effective culturally competent services; conduct random reviews of completed self-evaluation tools. Benchmarks will be measured by comparing the initial baseline data gathered and the results achieved.

The information to be evaluated will include, but not limited to:

1. Data analysis to determine access among targeted minority communities to culturally and linguistically appropriate services within a set period of time.
2. Percentage increase in the members of targeted communities who believe that they have access to culturally sensitive mental health services (i.e., making sure whether those services are being provided, the perception of available, appropriate services is addressed as well as the reality of providing those services).
3. Results of satisfaction survey ratings from mental health consumers receiving services from mental health agencies and other agencies.
4. Mental health providers who provide services and self-rate their ability to provide mental health culturally competent services.
5. Number of individuals identified as serving as “bridge builders” among targeted groups.
6. Percentage increase in the number of staff (clerical staff, psychiatrists, psychologists, social workers, and interpreters) qualified to provide services to members of targeted groups.
7. Percentage increase in the number of mental health professionals and mental health consumers participating in the process of designing materials to provide mental health services in culturally competent ways.
8. Number of available culturally responsive materials and protocols to be used by professionals as related to services to each of the targeted groups.
9. Number of mental health professionals and other staff attending training on the use of new culturally responsive materials.
10. Recommendations resulting from the assessment evaluation of legislation, policies and procedures related to mental health services to targeted populations.

**Measured, Concrete Achievements in Providing Services to Individuals from all Cultures and Ethnic Groups.** The state may measure the direct and indirect benefits of culturally competent
initiatives based on the achievement of the benchmarks and the collection and analysis of data. The information gathered will be used to recommend policies, procedures and programs, and to develop/enhance culturally competent materials, including Best Practices, to assist providers in the effective provision of their services.

**Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010**

*Access to Primary and Preventive Health Services:* Providers of services must comply with Title VI of the Civil Rights Act and Limited English Proficiency Guidelines that require the availability of written material and services in the primary language of the client.

*Adequate and Appropriate Nutrition:* Services provided must take into account cultural, ethnicity, and socioeconomic factors that may contribute to problems related to nutrition. The providers must also acknowledge traditions, religious beliefs, and ethnic backgrounds of the individuals to whom the services are being provided.

*Alcohol and Other Substance Use and Addiction:* Evaluation of individuals seeking this service must include a review of contextual ethnic/racial data and individual background information relative to potential or actual alcohol or other substance abuse patterns of use.

*Environmental and Occupational Health Hazards:* Provider should take into account relevant and applicable information relative to socioeconomic or home/work site characteristics (e.g., geographic location of the work site, housing and work segregation patterns, work conditions, and determine their impact of workers of particular ethnic/racial groups).

*Existing, Emerging, and Re-emerging Communicable Diseases:* Contextual data must be gathered, reviewed, analyzed, and made available to assist providers to effectively address issues in this area as related to individuals from various ethnic/racial/gender and other groups.

*High Risk Sexual Behavior:* Contextual cultural data will allow providers to effectively address this behavioral issue. Information regarding consequences and preferred behaviors should be made available in various languages. Information and strategies should include the acknowledgement of the cultural strengths prevalent in each culture that may deter individuals from exhibiting negative behaviors (e.g., respect for one’s traditions and one self).

*Intentional and Unintentional Injuries and Violence:* Traditional and nontraditional approaches which have been successfully used to proactively address prevention of injuries and violence should be sought out within the indigenous communities and replicated. Providers should consider working with natural leaders in order to provide information and assistance to members of the community in a manner that is culturally competent and acknowledges the nuances of language and traditions.

*Mental Health and Mental Disorders:* A culturally competent provider will take into account the traditions, religion, values, and beliefs of each individual receiving services. The “best practice” provider will access community resources and individuals that are knowledgeable of the client’s beliefs and when/if appropriate will use nontraditional approaches to working with the client.
Overweight, Obesity, and Lack of Physical Activity: Providers must acknowledge the need to develop traditional and nontraditional strategies and resources for persons of color that allow for sound advice and guidance regarding nutrition and exercise. These strategies must take into account the traditions, culture, and social practices of each of the groups that receive information and/or services from the provider.

Social and Economic Factors that Influence Health: Socioeconomic characteristics in each population should be evaluated from a contextual basis in order to determine specific strategies, resources, and information that needs to be available in order to provide effective and culturally competent services to individuals of the various cultural and racial, gender and other affected groups.

Tobacco Use and Exposure: Contextual data, which identifies specific information of each of the targeted populations, must be collected, analyzed, and used in order to determine the particular factors affecting the use of tobacco in each group and the appropriate strategies necessary to reach, inform and provide them with effective/culturally competent services.

Integrated Electronic Data and Information Systems: All data collection systems should comply with the requirements under Title VI of the Civil Rights Act as related to collection, analysis, and use of data that identifies numerically and programmatically the population served by gender, race, national origin, and ethnicity. That data must be updated and used on an on-going basis to ensure adequate and fair access and treatment of all individuals entitled to the service.

Community Health Improvement Processes and Plans: All processes and activities related to the program should have an adequate level of input from all targeted populations. When appropriate, information and activities should give non-English speaking individuals an opportunity to participate by providing translators or material translated in language other than English.

Coordination of State and Local Public Health System Partnerships: State and local Public Health partnerships should include input and participation from representatives from the various groups in the community to ensure that there participation occurs at all levels of the process from design to implementation. This will ensure that their concerns, issues, and needs are adequately reflected throughout the process rather than in a “reactive” manner.

Sufficient, Competent Workforce: A workforce that is representative of the population that we serve will allow for a natural response to the needs of a multicultural population. When individuals in the workplace reflect the culture, race, language, sexual orientation, religion, ethnicity, age, disabilities of the individuals served, the provider is not only meeting federal requirements, but in a natural way, is providing effective and culturally competent services.

Equitable, Adequate, and Stable Financing: The assessment and determination of what is necessary and appropriate relative to funding patterns and allocation should based on accurate, updated contextual data and information that identifies actual population needs and characteristics, the unique needs of the members of that community, and the need to comply with
federal and state regulations related to access to services and information (e.g., translations, reasonable accommodations, use of nontraditional services).

**Significant Linkages to Wisconsin’s 12 Essential Public Health Services**

_Educate the public about current and emerging health issues:_ Inform minority communities about the growing number of positive options they have in mental health services by using multiple media avenues in the target groups’ primary language.

_Promote community partnerships to identify and solve health problems:_ Encourage a wide variety of community and corporate partnerships by providing forums and other avenues of personalized outreach to bring individuals together to discuss issues and identify solutions.

_Create policies and plans that support individual and community health efforts:_ Create policies and effective evidence-based initiatives that make a positive difference in providing access to culturally competent referral and timely treatment by mental health consumers of all cultural/ethnic groups, their families, and the cultures/communities they live in.

_Link people to needed mental health services:_ Link people to appropriate mental health services by utilizing various means of communication, including technology, and working with advocacy groups and community leaders.

_Assure access to primary healthcare for all:_ Bilingual services and qualified culturally competent staff will ensure access to all services. Access to mental health services will be achieved by taking into account all variables necessary to address culture and language issues.

_Foster the understanding and promotion of social and economic conditions that support good health:_ Effective data collection and analysis, the dissemination of the results, and its use by providers will create additional awareness/knowledge as to variables affecting mental health issues in each targeted community. Collective efforts by all key stakeholders (e.g., state, business, community leaders) can result in the creation and maintenance of informational networks, preventive early intervention strategies, and effective use of available services.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

_Protect and Promote Health for All:_ This goal can be best achieved by recognizing the need to provide effective outreach to all eligible populations to understand and take into account cultural variables when designing and providing services and the need to provide culturally/linguistic appropriate services.

_Eliminate Health Disparities:_ If effective equitable services are to be provided to all populations, accurate and contextual data must be collected, analyzed, and used for the purpose of identifying needs, gaps, and available/necessary resources.

_Transform Wisconsin’s Public Health System:_ The public health system will be transformed if it acknowledges the differing and similar needs of various populations. The system must engage in a sustained dialogue and relations with natural and appointed leaders of all communities. Managers in the system must review their policies, procedures, and protocols to determine what
needs are to be modified, expanded, and/or changed in order to effectively and equitably provide services to all eligible to receive them.

**Key Interventions and/or Strategies Planned:**
There will be three stages to the initiative to build awareness, knowledge, and capacity regarding cultural competency. The following are action steps to be taken in each of these stages:

**Short Term:**
- Develop and/or implement a self-assessment tool for providers to determine their challenges and opportunities to provide effective services to targeted groups.
- Distribute available informational materials and training to enhance the knowledge of providers regarding strategies to address challenges identified in their assessment.
- In collaboration with providers, appointed officials and advocates, initiate research and review of policies and procedures that can have a positive impact on the equitable and fair delivery of services to targeted populations.

**Medium Term:**
- Assist providers in evaluating the overall impact of activities carried out in accordance to the short-term goals and objectives identified above.
- Seek input and information from mental health consumers in targeted communities to assess their level of satisfaction and their evaluation on the effectiveness of services that they were provided.
- In collaboration with providers, appointed officials, and advocates, develop recommendations for the creation, amendment, or modification of policies and procedures to enhance the capacity for providers and other stakeholders to provide full access to all services for consumers of mental health services in Wisconsin.
- Develop an assessment process that will allow Wisconsin to identify providers’ Best Practices and recognize those providers for the provision of equitable, fair, and culturally competent services.

**Long Term:**
- Create and utilize evaluation tools to be used to evaluate the overall implementation of the provider’s self-assessments and outreach strategies.
- Develop and make available to providers culturally competent models; and develop contract language with providers to ensure that they offer culturally appropriate services utilizing appropriate, credentialed, and culturally competent staff.
- Submit and promote legislation, policies, and procedure to ensure fair and equitable services to all mental health consumers in Wisconsin.

**References**

*A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, pp.11-21.

Federal Title VI of the Civil Rights Act of 1964.
Federal Americans with Disabilities Act.


Health Priority: Mental Health and Mental Disorders
Objective 4: Access to Care (Template)

Long-term (2010) Subcommittee Outcome Objectives:

4a: By 2010, Wisconsin’s public mental health clients who have access to "Best Practice" mental health treatments will increase by 10 percent.

4b: By 2010, Wisconsin's public mental health clients who have access to "Evidence-based" mental health treatments will increase by 10 percent.

Long-term outcome objective updated as of: Sept 2004

- Priority Ranking and Relationship to Healthy People 2010 - The Mental Health Subcommittee identified 86 initial objectives. Of the 11 semi-final objectives, the following related to access to services: (1) screen and serve children having difficulties in childcare and school for emotional problems; (2) establish mental health/substance abuse insurance parity; (3) address the shortage of mental health providers in children’s mental health, infant mental health, and geriatric psychiatry, especially in rural areas of Wisconsin; and (4) stimulate and fund innovative local mental health delivery services.

- Achieving this 10-year outcome objective will contribute to the shared vision of the public health system of healthy people in healthy Wisconsin communities as demonstrated in (a) a more healthy Wisconsin population; (b) a more productive population; (c) reduced suicides across the life span; and (d) improved family relationships.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of clients served through Community Support Programs in 2000 was 4,905. There are no current data to document Community Support Program's level of adherence to the evidence-based Program of Assertive Community Treatment model, but we will proceed under the assumption that Community Support Programs are evidence-based treatments for now. The objective is developmental because other evidence-based treatments and best practices are yet to be selected.</td>
<td>The number of Community Support Program clients is collected through the Community Support Program Monitoring Report. Future plans are to identify a limited number of “Best Practices” and “Evidence-based treatments” from the Center for Mental Health Services roster of treatments. The Community Support Programs which use the Program of Assertive Community Treatment model will be one of these. Then, use of these treatments will be tracked on a client-level basis such as through the Mental Health module of the Human Services Reporting System data system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Appendix A for baseline and target data on adults with mental disorders receiving treatment.</td>
<td>Healthy People 2010, November 2000, USDHHS, cites the following sources for this baseline data: Epidemiologic Catchment Area Program, National Institutes of Health, National Institute of Mental Health; National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Assistant Secretary; National Comorbidity Survey, Center for Mental Health Services</td>
</tr>
</tbody>
</table>
**Federal/National Baseline**

12% of families experience difficulties or delays in obtaining healthcare or did not receive needed care in 1996. This refers to all healthcare, not mental healthcare specifically.

---

**Federal/National Sources and Year**

*Healthy People 2010*, November 2000, United States Department of Health and Human Services, cites the following sources for this baseline data: Medical Expenditures Panel Survey, Agency for Healthcare Research and Quality (formerly Agency for Health Care Policy) and Research

---

### Related USDHHS Healthy People 2010 Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - Mental Health and Mental Disorders</td>
<td>Improve mental health and ensure access to appropriate, quality mental health services.</td>
<td>18-7</td>
<td>(Developmental) Increase the proportion of children with mental health problems who receive treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18-9</td>
<td>Increase the proportion of adults with mental disorders who receive treatment.</td>
</tr>
<tr>
<td>1- Access to Quality Health Services</td>
<td>Improve access to comprehensive, high-quality healthcare services.</td>
<td>1-6</td>
<td>Reduce the proportion of families that experience difficulties or delays in obtaining healthcare or do not receive needed care for one or more family members.</td>
</tr>
</tbody>
</table>

---

### Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based medicine</td>
<td>A decision-making framework that facilitates complex decisions across different and sometimes conflicting groups. It involves considering research and other forms of evidence on a routine basis when making healthcare decisions (Donald, 2002).</td>
</tr>
<tr>
<td>Mental health parity</td>
<td>Health insurance coverage for mental disorders that is no more restrictive than coverage for other health conditions.</td>
</tr>
<tr>
<td>Best practice guidelines</td>
<td>Guidelines, most generally developed by professional associations or expert panels, that identify what research and practice currently suggest is the most efficacious way to identify and respond to health conditions. Best practice guidelines generally identify evidence-based treatment as well as other practices that are believed to be useful in responding to a disorder, even though well-controlled scientific studies may not be available.</td>
</tr>
<tr>
<td>Recovery</td>
<td>As accepted by the Wisconsin Council on Mental Health (July 2001), recovery from a mental illness means the process of growth over time in the improvement of a person’s attitudes, feelings, values, goals, skills, and roles. Recovery is measured by a decrease in symptoms of illness and an increase in the person’s level of health, wellness, stability, self-determination, and self-sufficiency. Recovery means the development of hope, dignity, a new and valued sense of self, meaning and purpose, and quality of life.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Professional training schools</td>
<td>Schools of advanced education for healthcare professionals. These might include, but are not limited to, schools of nursing, social work, medicine and psychology.</td>
</tr>
<tr>
<td>Mental health/AODA redesign initiative</td>
<td>Four county-based sites developing under contracts with the Wisconsin Department of Health and Family Services to demonstrate how the recommendations of the Governor’s Blue Ribbon Commission on Mental Health can be implemented.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Prevention activities are those that occur before a mental illness is diagnosed. Prevention can be universal, selective, or indicated. Universal prevention programs are created for a whole population. Selective programs benefit members of an “at-risk” population. Indicated prevention is aimed at populations showing early signs and symptoms associated with mental disorders.</td>
</tr>
<tr>
<td>Early intervention</td>
<td>Action to hinder or alter a person’s mental disorder or abuse of alcohol or other drugs in order to reduce the duration of early symptoms or to reduce the duration of severity of mental illness or alcohol or other drug abuse that may result (Wisconsin State Statutes, Mental Health Act: s.51.01 Wis Stats).</td>
</tr>
<tr>
<td>Referral</td>
<td>The process of assisting an individual to obtain services from a health professional who can assess and treat, if necessary, a suspected health condition.</td>
</tr>
<tr>
<td>Assessment</td>
<td>The process used to evaluate an individual’s present problems with an accompanying description of the reported or observed conditions which led to the classification or diagnosis of the individual’s illness.</td>
</tr>
<tr>
<td>Partner systems</td>
<td>Service systems combining to work on increased screening in order to improve identification and referral of individuals who may be experiencing mental disorders. These include education, corrections, healthcare, social services, aging, child care, and early childhood.</td>
</tr>
</tbody>
</table>

**Rationale:**

As a first step in developing this 10-year long term outcome objective, the members of Mental Health and Mental Disorders Subcommittee spent time identifying current and emerging problems concerns access to care. These include:

**Problems identified:**
- People lack health insurance coverage.
- Most health insurance policies have more restrictive coverage for mental disorders.
- Insurers fail to utilize best practice “access to care” guidelines for persons presenting with mental disorders.
- Limited public funding for mental health services.
- Uneven availability of appropriately trained professionals to provide mental health services across the state.

**Outside influences:**
• Opposition to government-sponsored universal healthcare has prevented large-scale reform in this area. Incremental reforms have reduced the percentage of uninsured in Wisconsin, but may be inadequate for reducing uninsured to 0 percent.
• Economic health of the state and nation influences government’s ability to expand “publicly funded” healthcare.
• Rising cost of health insurance is straining business’ ability to expand health insurance coverage to employees.
• Polls have shown strong support for expanding access to healthcare, especially for children.
• Strong opposition to parity from small businesses and, to a lesser degree, from health insurers.
• State law cannot impact coverage for self-insured plans. This can only be done by federal legislation.
• Broad-based coalition of consumer, provider, citizen, faith-based, and labor groups support parity.
• Limited parity has been enacted on federal level. Additional action in the year 2001 will likely influence state efforts.
• Thirty-two other states have passed some form of parity legislation.
• Increasing research and development of consensus documents may facilitate efforts.
• Economic health of the state will impact ability to fund services if increased funds are required.
• Stigma continues to impact ability to fund mental healthcare.

Documentation:
• According to the Global Burden of Disease study commissioned by the World Health Organization and the World Bank, mental disorders represent 4 of the 10 leading causes of disability for persons age 5 and older. Among developed nations, including the United States, major depression is the leading cause of disability (Murray and Lopez, 1996).
• Twenty percent of the United States population has a mental disorder in one year; 3 percent has both a mental and addictive disorder; 6 percent has an addictive disorder (Regier et al., 1993).
• The indirect costs of mental disorders in 1990 were $78.6 billion (Rice and Miller, 1996).
• Ninety percent of people who kill themselves have depression or another diagnosable mental or addictive disorder.
• There are significant disparities in how mental disorders present themselves and are treated:
  • Major depression is diagnosed in twice as many women as men.
  • It is reported that racial and minority groups are underserved as compared to the majority population.
  • Depression rates are much higher among older Americans who experience a physical health problem.
• Of the 28 percent of the adult population with a mental or addictive disorder in a given year, only about one-third receive mental health services and, of these, less than half receive services from a mental health specialist. The rest receive care from medical, human services, or voluntary support. These numbers are similar for children (Regier et al., 1996; Kessler et al, 1996).
• Among the actions urged by the Surgeon General in his report on mental health are the following:
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state of the art treatment.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment (U.S. Department of Health and Human Services, 1999).

Outcomes:

**Short-term Outcome Objectives (2002-2004)**

- By 2003, there will be an increase, as measured by standard polling, in the percentage of the population that supports increased access to health insurance coverage.
- By 2003, citizens and policymakers will be aware of the hidden costs in failing to provide health insurance coverage to all persons.
- By 2003, changes that reduce insurance costs for small businesses will be identified.
- By December 2003, key stakeholders (e.g., providers, insurers, policymakers) will “buy-in” to best practice guidelines.
- By 2004, parity legislation will be passed in Wisconsin.
- By 2004, major state healthcare contracts (e.g., Medicaid/BadgerCare) will incorporate requirements for use of identified best practice guidelines.
- By June 2003, the public, legislators, and policymakers will have an increased awareness that serious mental illness is treatable and that recovery is possible.
- By December 2004, preliminary data from current projects will improve the knowledge base for making decisions about funding for mental health services.
- By 2004, three professional training schools for non-mental health specialists will agree to enhance their curricula to ensure that their professionals are better able to identify and respond to mental health disorders.
- By 2004, one new project involving technology to provide mental health treatment or consultation services to an underserved area will be implemented.

**Medium-term Outcome Objectives (2005-2007)**

- By 2005, policy changes will expand access to insurance through Wisconsin Medicaid and BadgerCare.
- By April 2005, legislators will have a clearer understanding of what they are “buying” when funding public mental health services and will therefore be more willing to do so.
- By 2005, legislation will implement small business health insurance reform that will reduce health insurance costs for small businesses and increase access to insurance for employees.
- By 2005, all commercial group health insurance policies in Wisconsin will implement the parity provisions.
- By 2005, citizens will be knowledgeable about their right to mental health services through their insurance companies.
- By 2005, insured individuals will receive medically necessary mental healthcare.
- By 2005, changes to program standards, policies, and statutes will be implemented that support use of best practice guidelines.
- By 2005, policies and practices that are barriers to access will be eliminated.
• By 2005, insurers and providers will be using best practice guidelines for persons in need of mental health services.
• By 2005, procedures will be in place for evaluating whether guidelines are being implemented properly.
• By 2005-2007, biennium funding for public mental health services will be based on number of persons needing services and better knowledge of the actual cost to provide services. Outcome indicators will guide funding decisions. (The actual level of funding may or may not increase based on the increase in the number of people served by the private sector, the use of more efficient services under managed care, etc.).
• By 2005-2007, biennium statutory changes will implement changes to state/county funding that result in adequate and equitable public funding statewide for mental healthcare.
• By 2007, two additional professional training programs for non-mental health specialists will enhance their training curricula.
• By 2007, two additional projects will use technology to provide mental health treatment or consultation services to underserved areas.

Long-term Outcome Objectives (2008-2010)
• By 2010, reduce by 10 percent the proportions of the population that reports difficulties, delays, or the inability to receive "Best Practice" mental health treatment.
• By 2010, increase the number of people with a mental health need to have timely access to evidence-based treatment.

Inputs: (What we invest – staff, volunteers, time, money, technology, equipment, etc.)
• Designated state staff to guide and develop the process
• Bureau of Community Mental Health/Division of Supportive Living
• Division of Public Health
• Wisconsin Medicaid – Division of Health Care Financing, Department of Health and Family Services
• Office of the Commissioner of Insurance
• Fiscal support to convene a mental health workgroup that will consist of identified leaders in the mental health field to oversee the implementation of the four Mental Health/Mental Disorders Subcommittee objectives.
• Fiscal support to develop and disseminate training materials on best-practice and evidence-based treatment.
• Distance learning technology to provide consultation on best-practice and evidence-based treatment.

Partner systems with the needed expertise to achieve the identified objectives:
- Business owners and their representatives
- Insurance carriers
- Legislators
- Mental health professionals
- Representatives from professional training schools
- Representatives from county human services
- Tribes
- Local health departments
• Investment of time from all identified individuals.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach—community residents, agencies, organizations, elected officials, policy leaders, etc.)*

**Activities:**
- Coalitions will be established/joined for enacting parity, enacting legislation to control health insurance costs for small businesses, and addressing other barriers to insurance.
- Uninsured populations will be identified.
- Reasons for lack of insurance will be identified.
- Solutions to lack of insurance will be identified.
- Strategies to implement solutions to lack of insurance will be put in place.
- Key parties (e.g., businesses, health insurers, legislators) will be contacted and educated.
- Public education will be provided through the media.
- Legislators and businesses will be educated about true costs and benefits of parity.
- Citizens and stakeholders will be informed about parity and mobilized to advocate with legislators.
- Stories will be presented in media to educate the general population about the need for and value of mental healthcare as part of treating the whole person.
- Model guidelines will be issued for access to treatment that identify timeliness standards, assessment and evaluation, treatment planning, and best practice or evidenced-based treatments.
- Proposed changes will be made to program standards, policies, and statutes.
- Informational hearings will be conducted to inform a wide audience of proposals and receive feedback.
- Model guidelines will be disseminated for access to treatment and best practice or evidence-based treatment.
- Ongoing monitoring of research will be conducted to identify potential revisions to guidelines over time.
- The Mental Health/Alcohol and Other Drug Abuse (AODA) Redesign Initiative will be implemented in four sites. Outcome and cost data will be determined.
- Proposals will be developed for best ways for state and county to share funding for public mental health services.
- Impact of recovery-oriented practices and prevention/early intervention practices will be documented and disseminated.
- Public awareness campaign will be implemented.
- Legislators will receive written information and face-to-face meetings educating them about efficacy of treatment and budget needs.
- Number and type of mental health professionals serving the state will be identified.
- Enhanced training and education of allied professionals to provide mental health services will be planned.
- Expanded use of technology to provide mental health services or consultation to underserved areas will be planned.

**Participation/Reach:**
The mental health workgroup formed to oversee implementation of Mental Health and Mental Disorders Subcommittee Objectives will include representatives from the following partner systems:
- Healthcare and HMOs
- Primary care
- Education
- Corrections - jails/prisons
- Social services
- Aging-including - area agencies on aging
- Child care and early childhood
- Local health departments
- Tribes
- Local mental health agencies and organizations
- Public and county organizations
- Wisconsin Department of Health and Family Services
- Legislature
- Statewide professional organizations, public health system disciplines and partners:
  - Wisconsin Health and Hospital Association
  - Wisconsin Primary Health Care Association
  - Wisconsin Nurses Association
  - Wisconsin Medical Society
  - Wisconsin Public Health Association

**Evaluation and Measurement**
The four mental health objectives combined will lead to the long-term outcomes identified above. The following table identifies objectives and measures that will allow us to evaluate our achievements.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A healthier Wisconsin population</td>
<td>Questions that have been added to Wisconsin’s Family Health Survey to measure prevalence of mental disorder among children and adults. Questions on mental health status</td>
<td>Family Health Survey-Department of Health and Family Services</td>
</tr>
<tr>
<td>A more productive Wisconsin population</td>
<td>Questions that have been added to Wisconsin’s Family Health Survey to identify degree to which mental or emotional problems interfere with functioning.</td>
<td>Family Health Survey-Department of Health and Family Services</td>
</tr>
</tbody>
</table>

*Template – Health Priority: Mental Health and Mental Disorders – Objective 4*
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced suicides across the life span</td>
<td>Number and rate of suicides by age group</td>
<td>National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics</td>
</tr>
<tr>
<td></td>
<td>Number of students in grades 9 through 12 who reported suicide attempts that required medical attention in the 12 months preceding the survey</td>
<td>Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
</tr>
<tr>
<td>Improved family relationships or social connectedness</td>
<td>Survey questions</td>
<td>Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
</tr>
<tr>
<td></td>
<td>Survey questions</td>
<td>National Health And Nutrition Examination Survey</td>
</tr>
<tr>
<td>Increase screening of mental health</td>
<td>Questions that have been added to Wisconsin’s Family Health Survey.</td>
<td>Family Health Survey-Department of Health and Family Services</td>
</tr>
<tr>
<td>Increased access</td>
<td>Number of adults aged 18 years and older who report symptoms of depression and that they received help from a mental health professional divided by number of adults aged 18 years and older who report symptoms of depression</td>
<td>Healthy People 2010 measure-- National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration</td>
</tr>
</tbody>
</table>

**Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010**

*Access to Primary and Preventive Health Services:* Improved access to mental health services will increase the likelihood that persons will see not only mental health specialists but primary care physicians as well. This will occur because the mental health professionals may help individuals identify certain primary care needs and also because some individuals will go to their primary care physicians to receive medications to treat their mental disorders.

*Alcohol and Other Substance Use and Addiction:* Rates of co-occurrence of mental disorders with alcohol and other drug abuse disorders are significant. Identification and treatment of a mental disorder will therefore also increase identification of persons with alcohol and other drug abuse disorders.

*High Risk Sexual Behavior:* High risk sexual behavior can occur in response to an unsatisfactory life situation. Treatment for mental disorders may identify individuals who are in such situations and provide for earlier intervention. This may lead to a reduction in persons engaging in high risk sexual behavior.

*Intentional and Unintentional Injuries and Violence:* Almost 600 people die from suicide each year in Wisconsin. Many others attempt but do not complete suicide. Increased access to mental health services will increase the likelihood that persons will see not only mental health specialists but primary care physicians as well. This will occur because the mental health professionals may help individuals identify certain primary care needs and also because some individuals will go to their primary care physicians to receive medications to treat their mental disorders.
Health services should help identify persons at risk for suicide and intervene before their mental disorder deteriorates.

Social and Economic Factors that Influence Health: Persons with mental disorders have a higher mortality rate than the general population and are less likely to receive basic medical care. By the identification and treatment of mental disorders, general health can be improved.

Tobacco Use and Exposure: Individuals with mental disorders have high rates of tobacco use. Screening, referral, and treatment may decrease tobacco use.

Integrated Electronic Data and Information Systems: Lack of good data about prevalence and outcomes of treatment for mental disorders makes it difficult to address mental health issues in many systems. Such data is critical to gaining support of non-traditional partners, such as legislators and the business community.

Community Health Improvement Processes and Plans: Because of the huge impact of mental illness on society (see rationale above) any community health improvement must address screening, referral, and treatment for mental disorders.

Sufficient, Competent Workforce: The supply of trained mental health professionals, especially those specializing in children and older adults and those competent to work with cultural/ethnic minority populations (e.g., Hispanic, Native American), undermines the ability to provide access to appropriate treatment.

Equitable, Adequate, and Stable Financing: Financing is a major issue. Public health systems are struggling to meet the needs of current clients and limits on private insurance coverage for mental disorders often leave individuals with no way to pay for identified treatment needs.

Significant Linkages to Wisconsin’s 12 Essential Public Health Services

Identify, investigate, control, and prevent health problems and environmental health hazards in the community: Improved access to mental health services will allow better control of the negative impact of mental disorders, prevent on-going difficulties and mitigate other health problems (since persons with mental illness have poorer health outcomes in other areas).

Educate the public about current and emerging health issues: The success of this objective rests on educating the public, including the legislature, that mental illnesses are real, common, and treatable. This involves understanding the costs of failure to treat mental disorders, the actual costs and success rates of providing treatment, and the long-range benefits of doing so.

Promote community partnerships to identify and solve health problems: The actions identified for this objective will require developing important partnerships with the legislature, the business community, and the insurance industry. The process also entails partnerships among mental health professionals and a wide range of other systems, including education, primary and acute care, aging, etc.

Create policies and plans that support individual and community health efforts: Development and/or dissemination of guidelines for access and treatment will support individual and community health
efforts. These guidelines will ensure the most efficient use of scarce resources and increase the likelihood for positive outcomes.

*Enforce laws and regulations that protect health and insure safety:* Link people to needed health services. Limitations on health insurance generally, and on insurance for mental healthcare in particular, are major barriers to individuals receiving mental healthcare. This objective seeks to remove those barriers.

*Evaluate effectiveness, accessibility, and quality of personal and population-based health services:* Best-practice and evidence-based guidelines represent an effort to identify and ensure effective health services for mental disorders.

*Assure access to primary healthcare for all:* Improved access to mental healthcare should also increase access to primary care, as individuals with mental disorders often do not have adequate access to primary care.

*Foster the understanding and promotion of social and economic conditions that support good health:* Success in this objective will require that the general public better understands the relationship between current limitations in health insurance for mental illness and poor health outcomes for individuals with these disorders.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

*Protect and promote health for all:* As noted in the “Rationale,” the burden of disease associated with mental illness is significant. Health promotion must address these conditions.

*Eliminate health disparities:* As noted in the “Rationale,” there are significant disparities in both the prevalence of certain mental disorders across different populations and the access to care for these disorders.

*Transform Wisconsin’s public health system:* The public health system is ideally situated to identify and respond to persons with mental disorders in an environment that does not come with the stigma that is attached to mental health services. By becoming more informed and competent in identifying and referring, the public health system will realize its potential to reduce the devastating effect that mental disorders have on individuals and on the community.

**Key Interventions and/or Strategies Planned:**

- Increase access to health insurance for Wisconsin citizens.
- Pass legislation mandating parity in insurance coverage for mental health and substance abuse treatment services.
- Develop model guidelines for access to care and delivery of best practices and work to have these adopted by providers and payors.
- Build on the recommendations of the Governor’s Blue Ribbon Commission on Mental Health, ensure adequate and equitable funding for public mental health services.
- Increase availability of trained professionals to provide mental health services in underserved areas in the State.
References:


Wisconsin State Statutes. S.51.01 Wis. Stats. Mental Health Act. Revisor of Statutes Bureau. Madison, WI.
### APPENDIX A

*Healthy People 2010*, November 2000, United States Department of Health and Human Services cites the following baseline and target data:

<table>
<thead>
<tr>
<th>Objective: Increase in Adults with Mental Disorders Receiving Treatment</th>
<th>1997 Baseline (unless noted)</th>
<th>2010 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-9a Adults aged 18 to 54 years with serious mental illness</td>
<td>47 (1991)</td>
<td>55</td>
</tr>
<tr>
<td>18-9b Adults aged 18 years and older with recognized depression</td>
<td>23</td>
<td>50</td>
</tr>
<tr>
<td>18-9c Adults aged 18 years and older with schizophrenia</td>
<td>60 (1984)</td>
<td>75</td>
</tr>
<tr>
<td>18-9d Adults aged 18 years and older with generalized anxiety disorder</td>
<td>38</td>
<td>50</td>
</tr>
</tbody>
</table>