

## Mobilization Plan Delegation to Improve Behavioral Health

### Introduction

Dane County is considered a good place to live, but its population is not immune from behavioral and mental health<sup>1</sup> issues. The Surgeon General of the United States has said that mental health is fundamental to health, and that mental disorders are real and treatable health conditions that have an immense impact on individuals and families.

We're as likely to see family members, co-workers, or people within our own social circles struggling with behavioral health problems as we are to see the impact of untreated behavioral/mental health disorders in people on the street or in the news who commit crimes or are violent. The onset of a mental disorder is not an overnight event. There are identifiable signs. The disorders are real and treatable. And there are strategies to protect – both individuals from themselves and the community from the broad effects of this critical issue.

Though Dane County is viewed by some as a resource-rich community<sup>2</sup>, behavioral/mental health resources in particular are fragmented, and often difficult to access when needed. An additional problem is the lack of capacity to identify and provide early intervention and treatment. Solutions in this area are made more complex as we consider the stigma that prevents people from seeking help, differential patterns of insurance coverage, and lack of coverage for some.

The Delegation to Improve Behavioral Health<sup>3</sup> was convened to examine whether the existing configuration of behavioral health services – established over twenty years ago with the movement away from institutions to community-based care – effectively meets current needs. A key focus was to identify solutions to fragmentation and duplication in the system that result in:

- gaps that hinder the continuity of care;
- inefficient use of existing resources;
- limits in service capacity; and
- an inability to adopt new best or promising practices.

The Delegation presented a set of recommendations to the Health Council<sup>4</sup> for improving access to behavioral and mental health care in Dane County that included strategies for expanding capacity, helping consumers access the proper services they need, and introduces newly discovered best practices/evidence for more effective care. These recommendations are provided in Appendix C of this report.

They further guided United Way toward adopting a specific focus on psychological trauma. Trauma is one of the key leverage points that can underlie serious behavioral health problems and contribute to problematic behaviors, life circumstances, and community consequences for both children and adults. The Delegation recommended a focus on the early identification and treatment of behavioral health issues with a particular emphasis on improving family health. This Mobilization Plan is focused on the trauma-related recommendations of the Delegation's work.

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<sup>1</sup> Definition of mental health—the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity, from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. From The Executive Summary—A Report of the Surgeon General on Mental Health, 1999.

<sup>2</sup> Dane County has long been recognized as a national leader in providing community-based treatment and support services that help people with significant, life-long mental illnesses live in the community.

<sup>3</sup> Delegation roster is provided in Appendix A.

<sup>4</sup> Health Council roster is provided in Appendix B

## I. Problem Statement

Challenges created by behavioral and mental health issues are encountered to varying degrees in every area of our community. Based on national data, we estimate that nearly 105,000 (26%) of the 383,000 adults in Dane County experience mental health problems with depression and anxiety being the most prevalent affecting nearly 76,000. Another 16,700 children and youth under 18 also experience behavioral health problems. Even though there are over 645 mental health providers and a \$200+ million treatment system in Dane County, many people can only access treatment for behavioral and mental health care in Dane County through a high-cost back door such as the jail or hospital Emergency Department instead of outpatient community resources. Others don't seek help because they don't recognize they have a problem, think they can handle it on their own, or fear the stigma associated with mental illness. Behavioral health issues are also the second-leading cause of disability.

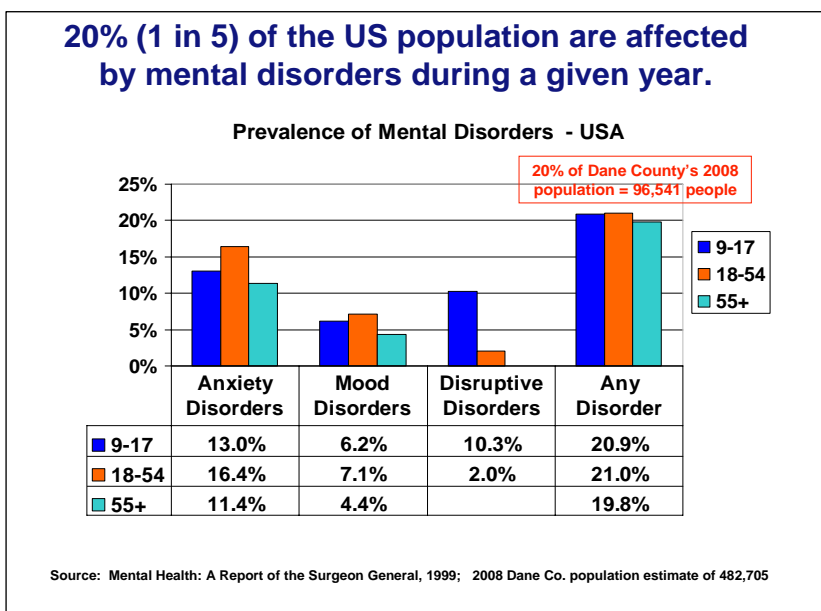
### Why this Matters

- **Behavioral health is linked to overall well-being:** Physical and emotional health are closely tied. They are the foundations upon which a person's sense of overall well-being is based. Healthy individuals are likely to graduate from school, be productive in the workplace, behave appropriately in community settings and develop healthy relationships with others. Healthy relationships contribute to safe and healthy communities.
- **Help is available but access can be difficult:** Most behavioral health issues can be effectively managed or cured with treatment. Over \$200 million is spent on behavioral health care in Dane County each year for an estimated 121,000 children, youth, and adults. Yet the system is considered clogged and people have a difficult experience in accessing treatment. This is particularly true for those who have a health insurance benefit, but without a strong mental/behavioral health benefit.
- **Trauma as a "root-cause" trigger:** Research shows that trauma is an underlying cause of many behavioral health issues. Effective treatment is available, yet our service system in Dane County does not link victims efficiently nor consistently use "trauma informed" best and promising practices.

## II. National Research on the Problem

### A. Scope

Twenty percent of the population – nearly one in five individuals – will experience a behavioral/mental health problem during their lifetime. It may be a one-time event of short duration with a known cause (for example, depression following the loss of a spouse), a life-long illness such as schizophrenia with a biological etiology, or something in between. It may resolve on its own or with relatively little intervention or require ongoing treatment with medication and/or other therapies.



These are examples of disorders that fall under the “psychiatric illnesses” or “mood disorders” categories in the DSM IV<sup>5</sup>. They are also the two faces of behavioral and mental health problems that are likely to be most visible or known by the general population, either through media coverage of an unsettling community event that involved an individual with schizophrenia, or perhaps by knowing a family member or close friend in the throes of a clinical depression.

Depression is a major issue because it affects so many people and can have dire consequences for some. Each year seven percent of the US population experiences clinical depression. Twelve to fifteen percent has had a depressive episode at some point in their life. About fifteen percent of the US population will have a major depressive episode by age 40, with 10-15% committing suicide. Yet less than half of those who have depression receive treatment. Reasons for this include misdiagnosis, a fragmented healthcare system that makes finding the right services difficult, the stigma associated with mental illness, and not knowing where or how to ask for help.

On the opposite end of the spectrum is schizophrenia which is a major issue because of the severity of the illness – but it is one that affects very few, only one percent of the population. Treatment is deep and expensive, requiring a combination of antipsychotic medication, talk therapy, assistance to live independently and minimize substance abuse. (Dane County spends significant public resources to support these individuals so they do not pose harm to themselves or others in our community.)

Similarly, individuals with bi-polar disorder represent two to three percent of the US population. Mood stabilizing medications are effective in evening out periods of manic or depressive behaviors but treatment compliance is poor when drug regimens are discontinued once the person feels better.

In sum, behavioral and mental health problems are common and often hidden/unseen. They affect children and adults, can be short-term or ongoing, and can be effectively treated or managed. Depression is the most frequently-occurring problem and therefore one that has the broadest impact on families and the workplace. It is also highly/disproportionately undertreated.

## **B. Mental Health and Substance Abuse**

Substance abuse refers to the abuse of alcohol, illicit drugs, or both.<sup>6</sup> The 2005 National Survey of Drug Use and Health<sup>7</sup> showed that over 24 million people in the United States ages 12 and over experienced a substance use or substance dependence disorder. This represents 9.5% of the general population.

Once regarded as a personal weakness, neuroscience and other research is reshaping our understanding of addiction as “a chronic disease with characteristics and implications for treatment and recovery that are similar to other chronic diseases.”<sup>8</sup> This does not apply to everyone who uses or abuses addictive substances, but for those for whom it does, appropriate treatment includes an acute phase of care followed by support and help with managing the disease on an ongoing basis.

Mental illness and substance abuse are intertwined<sup>9</sup>. Someone who deals with both issues is said to have a “co-occurring disorder”. Research suggests that the presence of a severe mental

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<sup>5</sup>The “*Diagnostic and Statistical Manual of Mental Disorders*” is published by the American Psychiatric Association and contains a list of psychiatric disorders and their associated diagnostic codes.

<sup>6</sup> “*An Employers Guide to Behavioral Health Services*” Center for Prevention and Health Services, National Business Group on Health, 2010.

<sup>7</sup> Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health, 2005.

<sup>8</sup> Integrating Appropriate Services for Substance Use Conditions in Health Care Settings – An Issue Brief on Lessons Learned and Challenges Ahead, Forum on Integration, A Collaborative for States; July 2010.

<sup>9</sup> Ibid.

illness (SMI) correlates with a higher risk for addiction. Estimates are that 29% of all people diagnosed as mentally ill abuse either alcohol or drugs. Conversely, 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness.<sup>10</sup>

The correlation between trauma and substance use is also strong. Numerous studies show that trauma is a risk factor for substance abuse, particularly in adolescents. Teens who experience sexual abuse/assault are three times more likely to report past or current substance abuse than those without a history of trauma.<sup>11</sup> Other studies have found that more than 70% of adolescents receiving treatment for substance abuse had a history of trauma exposure.<sup>12</sup>

Trying to tease apart which came first, the illness or the substance abuse, can be a futile activity. For some, turning to alcohol or drugs can be a way of self-medicating to escape from emotional pain. For others, the mental illness came first. In either case effective treatment addresses both problems simultaneously.

In most communities, treatment for mental health and substance use problems has not been well integrated. Separate funding streams for public dollars have driven the creation of siloed rather than integrated treatment systems. That is beginning to change.

### C. The Adverse Childhood Experiences Study (ACE)

The Adverse Childhood Experiences Study<sup>13</sup> is the longest ongoing longitudinal study that explores the relationship of how experiences in childhood impact a person's health as an adult. Conducted by the Department of Preventive Medicine at Kaiser Permanente in San Diego, CA

in conjunction with the Centers for Disease Control, health histories of more than 17,000 largely white, middle class, insured adult patients "reveal a powerful relationship between our emotional experiences as children and our physical and mental health as adults, as well as the major causes of adult mortality in the United States. It documents the conversion of traumatic emotional experiences in childhood into organic disease later in life."<sup>14</sup>

<b>Table 1. The Adverse Childhood Experiences Study</b>	
<i>Growing up experiencing any of the following conditions in the household prior to age 18 is an incident of an "Adverse Childhood Event"</i>	
<b>Abuse</b>	
<i>Categories</i>	
▪ Recurrent physical abuse	
▪ Recurrent severe emotional abuse	
▪ Contact sexual abuse	
<b>Household Dysfunction</b>	
<i>Growing up in a household ...</i>	
▪ Where the mother was treated violently	
▪ Where at least one biological parent was lost during childhood	
▪ Where someone was chronically depressed, mentally ill, or suicidal	
▪ Where there is emotional or physical neglect	
▪ With an alcoholic or drug abuser	
▪ Where someone was in prison	

*Definitions of these categories can be found in Appendix D.*

This research studied eight categories of childhood abuse and household dysfunction. (See Table 1) A simple scoring method is used to determine the extent to which an individual has been exposed to childhood trauma. Each category equates to a single "dose" of an adverse childhood experience. Even as new research is published annually, the ACE study documents a strong, graded

<sup>10</sup> Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study Vol. 264 No.19, November 21, 1990 <http://jama.ama-assn.org/cgi/content/abstract/264/19/2511>

<sup>11</sup>From a source cited in *Making the Connection: Trauma and Substance Abuse* published by The National Child Traumatic Stress Network

<sup>12</sup> Ibid

<sup>13</sup> Adverse Childhood Experiences Study Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al JS. *The relationship of adult health status to childhood abuse and household dysfunction.* American Journal of Preventive Medicine. 1998;14:245-258.

<sup>14</sup> Ibid

correlation between multiple exposures to childhood trauma and higher incidences of organic diseases such as hepatitis and chronic obstructive pulmonary disease, unhealthy or risky behaviors like smoking and drug use, and emotional disorders. [The average age of study participants was 57 years. Results demonstrate that the cumulative impact of childhood trauma can be seen in adults even 50 years later.]

“Dosage”- or the number of exposures to an adverse childhood event - is an important predictor of who is likely to be most susceptible to health and emotional problems throughout their lives. An ACE score of 4 or more significantly increases the probability that physical and emotional health will be fragile if not compromised. The ACE study makes a strong case for providing protective and nurturing environments for children and for recognizing that behavioral and mental health problems in some adults may have been triggered but not adequately addressed long ago.

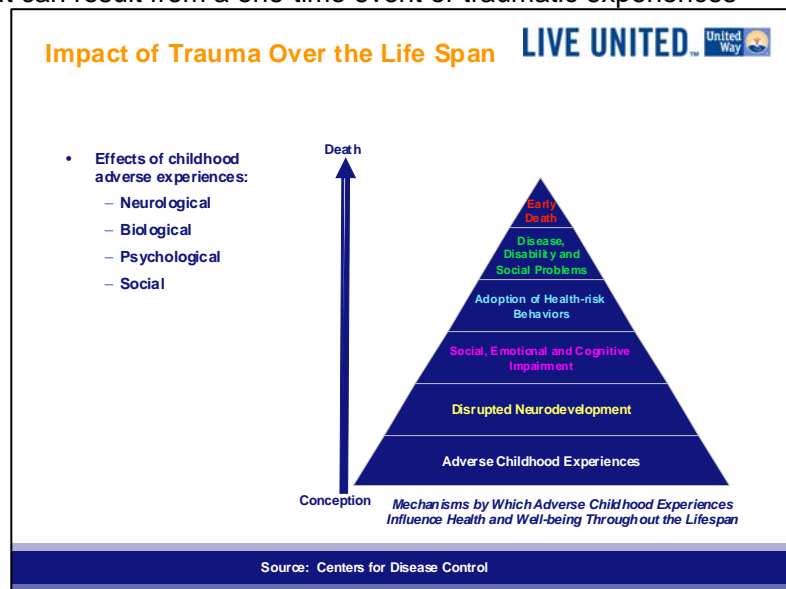
A growing body of research provides answers to how and why traumatic childhood experiences can lead to poor physical and emotional health over a lifetime. Neuroscience has provided brain imaging that show changes in the chemical composition occurs in the brain under extreme or prolonged stress. The brain is essentially re-wired as a protective “fight or flight” state is needed to mobilize behaviors and thought processes that ensure safety. Over the long term this can impair normal social, emotional, and cognitive development. Self-medicating behaviors like eating, drinking, smoking, and using drugs may occur in the absence of effective treatment. These, in turn, result in a variety of unhealthy conditions and negative outcomes well-documented in the medical and psychological sciences literature.

#### D. Trauma

Trauma is a major trigger for behavioral health problems including the use of substances as self-medication. **Psychological trauma is defined as an experience that is emotionally painful, distressful, or shocking, which can result in lasting emotional and physical affects<sup>15</sup> and overwhelms one’s ability to cope.** It can result from a one-time event or traumatic experiences that are interpersonal, intentional, prolonged and repeated such as domestic abuse.

The damaging consequences of trauma can be seen in these facts:

- 90% of mental health clients have been exposed to a traumatic event and most have multiple experiences of trauma (Muesar, 1998)
- 92% of incarcerated girls reported sexual, physical or severe emotional abuse in childhood (Acoca & Dedel, 1998)
- A Wisconsin study of women prisoners found that 58% reported a history of childhood sexual abuse; 42% extreme repeated childhood physical abuse; 65% had been the victims of repeated domestic violence (Saviano, 1999)



<sup>15</sup> “Creating Trauma-Sensitive Schools: Speaker Notes Part One – What is Childhood Trauma & How Does It Affect Children?” WI Department of Public Instruction, 2010

- In Wisconsin, 80% of women in treatment for substance abuse disorders have experienced a traumatic event over their lifetimes (BMHSAS Data, 2003-2005)
- More than 40% of women on welfare were sexually abused as children. They often are unable to hold a job and become homeless, (DeParle, 1999)

The common denominator seen in these different life circumstances is the presence of a trauma history in these individuals' lives.

<b>Trauma can be...</b>	<b>And triggered by things like ...</b>
<i>Acute:</i> a one-time event, does not usually affect deep layers of the personality	<i>The events of September 11, 2001; the sudden and unexpected death of a loved one or close friend; loss of home by fire</i>
<i>Complex:</i> persists over time, traumatic experiences that are interpersonal, intentional, prolonged and repeated	<i>Victim or witness of violence, including sexual abuse; victim or witness of verbal and emotional abuse; bullying</i>

### E. Access to Care

There are significant barriers that prevent people from accessing the behavioral health services that could help them. These include the lack of, or limited, insurance coverage for behavioral health; mismatches between payer sources and available providers; shortages in the supply of psychiatrists and/or other professionals who can prescribe medications, and the stigma that surrounds mental illness.

Public policy has attempted to equalize insurance coverage for behavioral health care. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 put coverage for behavioral health care on par with other medical disorders. Yet the law applies only to employers who offer health insurance benefits and have 50 or more employees. Provisions in the Patient Protection and Affordable Care Act of 2010 hold promise for making behavioral healthcare more affordable and accessible for all. However, legal challenges and attempts to repeal this healthcare law may stop its implementation. Thus, for many, hospital emergency departments and jails become the providers of last resort where people end up when unable to obtain behavioral health treatment elsewhere. These are high-cost delivery sites that cannot provide the follow-up care and ongoing supervision treatments require.

Despite the numerous barriers, most people seek care through their primary care provider rather than specialty mental health care practitioners. Research shows that 43% to 60% of patients with psychological problems are treated only in primary medicine, while 17-20% of patients with these problems are treated in the specialty mental health system.<sup>16</sup> The co-existence (comorbidity) of psychological and physical health problems, such as the link between depression and diabetes or heart disease, has also been well-documented. Patients with behavioral and medical comorbidities have 30 to 100% higher non-mental health utilization of health care resources.<sup>17</sup>

Primary care providers typically under identify mental health problems in their patients.<sup>18</sup> When they do identify such problems, they may not have the expertise to effectively treat and follow patients with these disorders. A growing body of research supports the value/efficacy of evidence-based psychological interventions as part of the treatment of medical issues. Addressing both the physical and psychological problems has been found to reduce hospitalizations, visits to the doctor and emergency room, medication costs, pain levels, etc.<sup>19</sup>

<sup>16</sup> "Primary Care Is the De Facto Mental Health System" Chapter 2 in Collaborative Medicine Case Studies: Evidence in Practice. Rodger Kessler and Dale Stafford, Springer Science and Business Media LLC, 2008.

<sup>17</sup> Ibid

<sup>18</sup> "Integrating Mental Health Treatment Into the Patient Centered Medical Home", Agency for Healthcare Research and Quality. Publication No. 10-0084-EF, June 2010

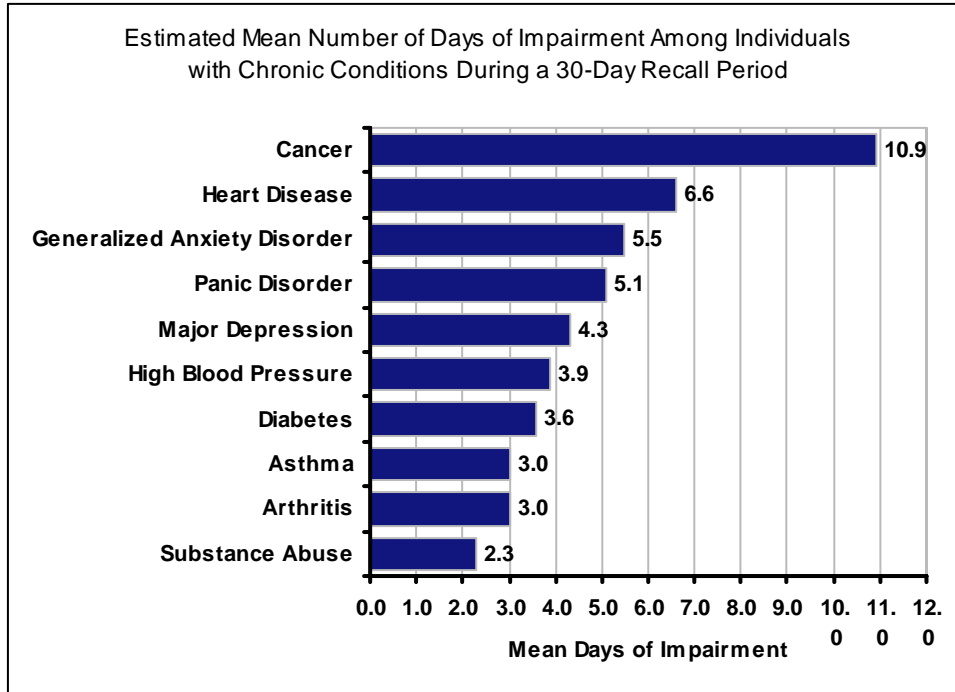
<sup>19</sup> "Primary Care Is the De Facto Mental Health System" Chapter 2 in Collaborative Medicine Case Studies: Evidence in Practice. Rodger Kessler and Dale Stafford, Springer Science and Business Media LLC, 2008.

## F. Behavioral Health and the Workplace

Behavioral health problems are among the top causes of disability and lost productivity in the workplace. Estimated total workplace costs of mental illness and substance abuse in the US, including the indirect costs of excess turnover, work impairment (“presenteeism”) absenteeism and disability, range from \$79 billion to \$105 billion per year (based on 1990 dollars).<sup>20</sup>

Employer costs for an employee on short-term disability leave due to mental health concerns have been estimated at nearly \$18,000.<sup>21</sup> Disability leave due to mental illness costs employers nearly twice as much as one due to physical illness.<sup>22</sup>

Employers recognize the importance of a healthy workforce.



Source: Kessler RC. Greenberg PE. Mickelson DK. Meneades LM. Wang PS The effects of medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*, 2001; 43(3):218-225. Found in *An Employer's Guide to Behavioral Health Services*.

require higher co-pays, visit limits, and management of utilization.”<sup>23</sup>

Both the employee and employer benefit when health insurance and workplace wellness and employee assistance programs are offered/available. Most insurance products offered through the workplace do not provide behavioral health benefits that are on par with medical benefits. “Access to specialty mental healthcare

services is constrained by benefit designs that

<sup>20</sup> “An Employers Guide to Behavioral Health Services” Center for Prevention and Health Services, National Business Group on Health, 2010.

<sup>21</sup> “Mental Health Leaves Most Costly Disability to Canadian Employers, Study Finds” [ScienceDaily](#) September 10, 2010.

<sup>22</sup> Ibid

<sup>23</sup> “New Employer’s Guide to Behavioral Health Services Calls for Integration of Services” Mental Health Works, Fourth Quarter 2005. Published by the American Psychiatric Association and the American Psychiatric Foundation.

### **III. National Research on Strategies that Work**

#### **A. Mental Health and Substance Abuse**

Effective treatment addresses both problems simultaneously. The first step is detoxification which clears the alcohol/drugs from the body and is most safely done under medical supervision. Once that is completed, a two-pronged treatment approach should occur: 1) rehabilitation for the substance use problem through a combination of psychotherapy, education about alcohol and drugs, peer recovery groups, and other mind-body wellness techniques, and 2) treatment for the psychiatric problem. This will be tailored to the diagnosis but typically includes a combination of therapy and medication.

#### **B. Trauma**

##### **1. Treatment Principles**

With appropriate treatment, the effects of trauma can be mitigated and recovery is possible. In much the same way as a recovering alcoholic strives to stay sober, trauma will always be a part of a survivor's experience but they can heal and gain tools that will equip them to manage fears and feelings that continue to surface throughout their lives. Effective treatment is trauma-specific. It directly addresses the impact of trauma on an individual's life and facilitates trauma recovery.<sup>24</sup> Treatment aims are three-fold: processing and coming to terms with the traumatic event(s); learning grounding techniques and skills to manage physical and psychological stress reactions in a healthy way; and re-establishing safe, secure emotional and social connections.

There is no definitive research about whether receiving early treatment for trauma is more beneficial than receiving it later. Logic suggests this would be the case, but there is no scientific evidence to support this assumption. In fact, some have suggested that "early intervention disrupts defenses and coping strategies, whereas late intervention has the advantage of providing psychological aid when these mechanisms are stronger."<sup>25</sup>

##### **2. Cognitive Behavioral Intervention for Trauma in Schools**

The Cognitive Behavioral Treatment for Trauma in Schools (CBITS) program began in Los Angeles, CA in 2000 and has been adapted for implementation in schools in Dane County. This research-based early intervention program screens youth in sixth grade for symptoms of post traumatic stress disorder (PTSD) and depression. It is based on the premise that reducing symptoms, increasing coping and adaptive skills (resiliency), and providing support from peers and parents help children who have witnessed or experience trauma to heal.

The program also provides short term group intervention in concert with schools and parents. Several national studies have documented statistically significant improvement in PTSD symptoms for students receiving this intervention. At three-month follow-up, CBITS students reported significantly greater reduction of PTSD symptoms than a control group that was put on a waiting list prior to treatment (64% reduction from baseline compared with a 34% reduction from baseline). The same pattern was true for symptoms of depression – a 47% reduction in symptoms from baseline for CBITS students compared with a 24% reduction for the wait-listed control group.<sup>26</sup>

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<sup>24</sup> *Trauma Informed Treatment in Behavioral Health Settings*. Ohio Legal Rights Service, January 2007

<sup>25</sup> "A Review of Psychological Debriefing After Extreme Stress", Kaplan et al. *Psychiatric Services* 52: 824-827, June 2001.

Published by the American Psychiatric Association

<sup>26</sup> Stein, et al, 2003.



## C. Access to Care

### 1. Integrated Care

Achieving better outcomes for patients when both physical and behavioral health issues are addressed is a driving factor toward a new, integrated model of primary care where medical and behavioral practitioners work closely together. Particularly effective is having both providers in the same setting, able to independently see patients during the same appointment. Lower no-show rates for appointments, increased patient and provider satisfaction, better patient compliance with medications, and a more cost-effective visit have all been found to result.

We are likely to see increases in the number and variety of holistic primary care models in the coming years. Payment reforms that reward quality of care and good patient outcomes rather than the number of tests done or services billed are a second driver moving medicine in this direction.

### 2. Behavioral Screening and Intervention

Behavioral Screening and Intervention (BSI) is an evidence-based, cost-efficient model for identifying and addressing alcohol “misuse”, nicotine addiction (smoking) and depression in a primary care, emergency department or hospital setting. It involves universal screening by questionnaire or interview for these conditions and for patients with positive screens, a brief validated assessment to determine the level of risk or problem. Research shows that the majority of patients with positive screens are at a mild-to-moderate risk of having these issues develop into severe problems. In these cases, motivational interviewing, brief interventions, primary care management and other strategies that encourage a patient to seek early treatment show promising results in preventing more severe problems. The smaller number of individuals with the most severe problems can be referred for a more complete assessment and specialized treatment. BSI leads to improved diagnosis and treatment of depression, decreased risky drinking (reductions of 20% in Emergency Department visits; 37% in hospitalizations, 47% in car accidents; 50% in arrests),<sup>27</sup> and increased tobacco quit rates.

Much data is available to show the cost savings stemming from BSI. Once a barrier, an increasing number of payers now pay for BSI.

## D. Behavioral Health and the Workplace

The National Business Group on Health has elevated within the business community the importance of addressing behavioral healthcare needs in insurance products offered to employees. The purchasing power of employers can be used to influence changes that can improve access to behavioral health treatment through:

- *Plan designs with equalized benefits* – out-of-pocket costs for behavioral healthcare services that are comparable to out-of-pocket costs for medical care. Plans should be designed to promote and improve collaboration between the health and behavioral health providers.
- *Disability management* – develop a proactive and integrated approach for managing disability related to behavioral health disorders
- *Employee assistance programs (EAPs)* – assure that EAP services complement and support, rather than overlap with, behavioral health services provided through health plans.

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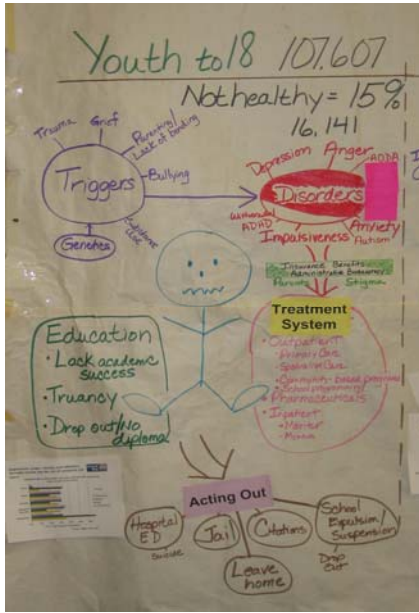
<sup>27</sup> Presentation to the Delegation to Improve Behavioral Health by Richard L. Brown, MD, MPH, Professor, Department of Family Medicine, UW School of Medicine and Public Health.

## IV. Local Research

### A. Data

#### 1. Scope: Adults

We estimate that 105,000 adults in Dane County deal with some sort of mental or behavioral health problems in any given year. This figure is based on applying the national mental/behavioral health problem prevalence rate of 26% to Dane County's adult population.



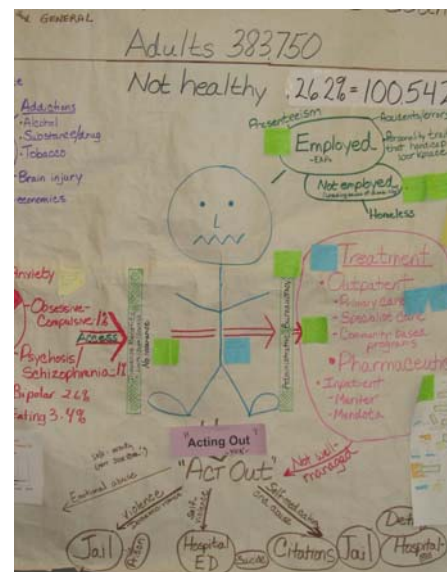
More specific estimates are available when particular disorders are considered. The rate of mental health issues in Wisconsin is 11.6% for individuals suffering from serious psychological distress, and 7.95% for those suffering from a major depressive episode; results are significantly higher than our neighbors from either Illinois or Minnesota.<sup>28</sup> A recent study found that 8% of Wisconsin adults reported experiencing frequent mental distress, defined as 14 or more mentally unhealthy days (“stress, depression and problems with emotions”) during the previous 30 days.<sup>29</sup> In Dane County that translates to 37,680 individuals.

The number of 65+ adults in Dane County with mental or behavioral health problems is small and easier to count. In 2010, there were 6,325 adults ages 65 and over with dementia. All but 725 (12%) were 75 or older.

#### B. Scope: Children and Youth

About 16,000 Dane County children and youth experience mental or behavioral health problems in any given year. This estimate is based on applying the national mental/behavioral health problem prevalence rate of 15% to our county's youth population. We have a better picture of behavioral health issues seen in our community's school-aged children and youth. Data was collected in partnership with the Madison Metropolitan and Sun Prairie School Districts during the 2006-2007 school years. Student services staffs such as psychologists, social workers, nurses, etc. were asked to provide information about students they felt were dealing with a mental/behavioral health issue that was interfering with their ability to learn. While not a rigorous scientific diagnosis-based analysis, the aggregated data provided a helpful window into the mental well-being of students that had not previously been available. Among the findings:

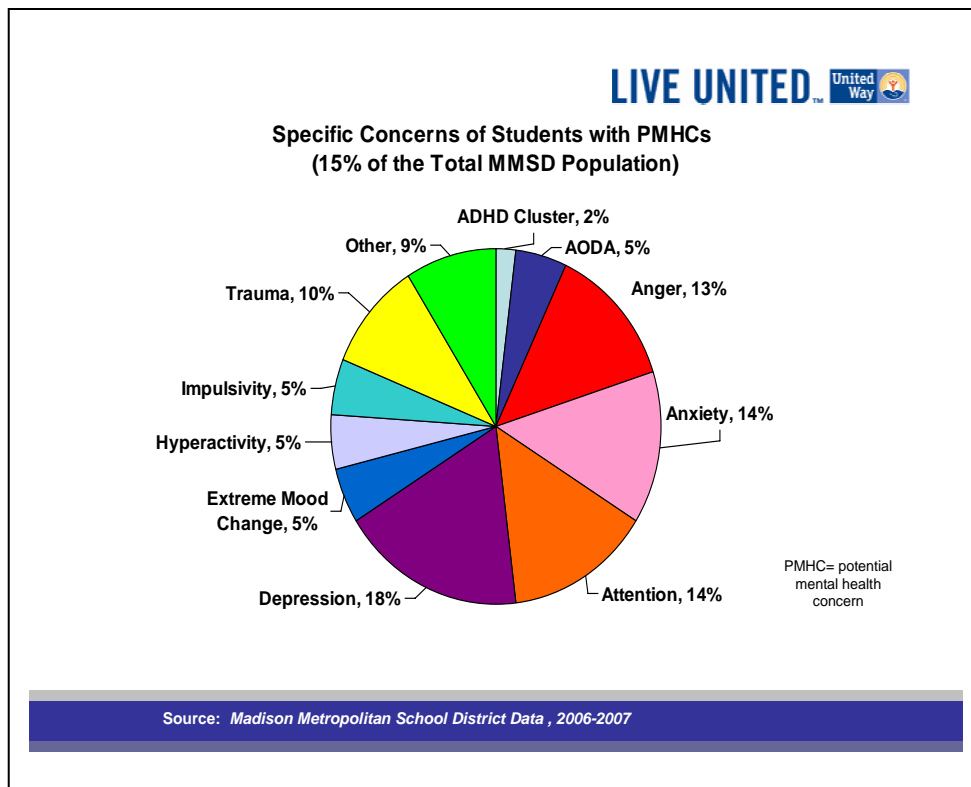
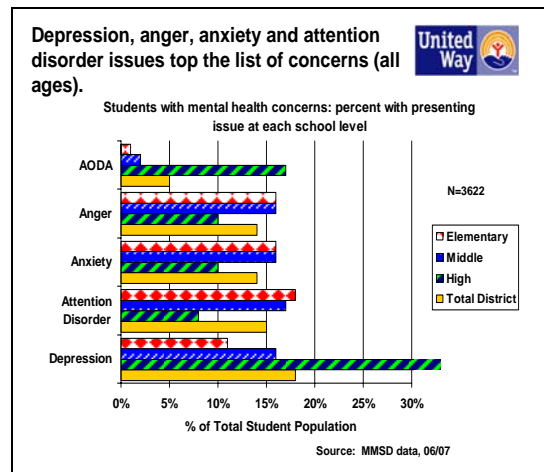
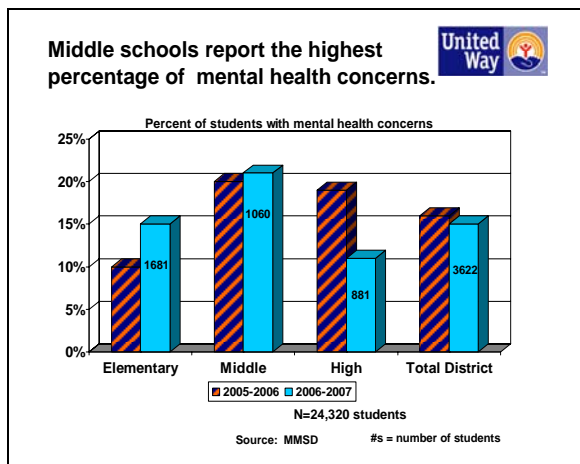
- **The picture locally is right in line with national estimates.** About 15% of students were dealing with some kind of mental/behavioral health concern.



<sup>28</sup> SAMHSA, Office of Applied Studies, National Survey of Drug Use and Health 2005-2006, Wisconsin data

<sup>29</sup> Data from Centers for Disease Control Behavioral Risk Factor Surveillance System; Geographic Patterns of Frequent Mental Distress U.S. Adults, 1993-2001 and 2003-2006. April 2009.

- **Middle schools deal with the highest proportion of students with behavioral health concerns.** It should be noted, however, that reported high school numbers were less reliable than for students in elementary and middle schools. High school teachers and staff may not be as aware of students dealing with these issues because they aren't in as close contact with students and their families at this age as teachers of younger children are. Additionally, some students may in fact be receiving help for their concerns completely outside of the school setting.
- **Depression, anger, anxiety and impulsivity topped the list of behavioral health concerns for all ages.** Depression is an issue at all grade levels. Substance use is a concern at upper grade levels.
- **The top behavioral health concerns are consistent across all grade levels.** The top four concerns are depression, attention disorder, anger and anxiety.
- **Trauma is a concern for about 10% of students.** This suggests that about 2,400 students had witnessed or been exposed to something that was a traumatic experience for them.

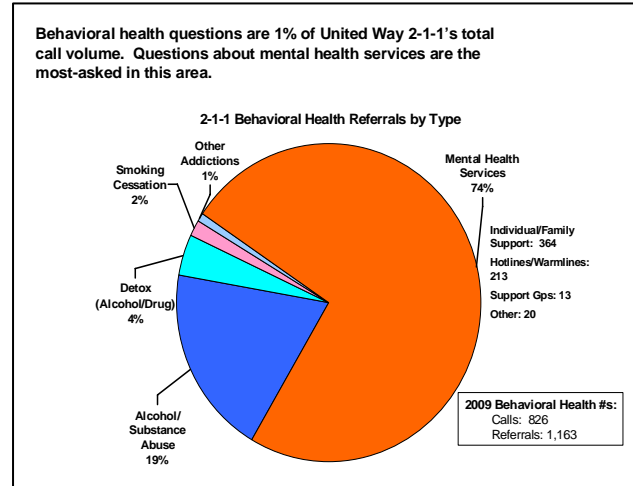
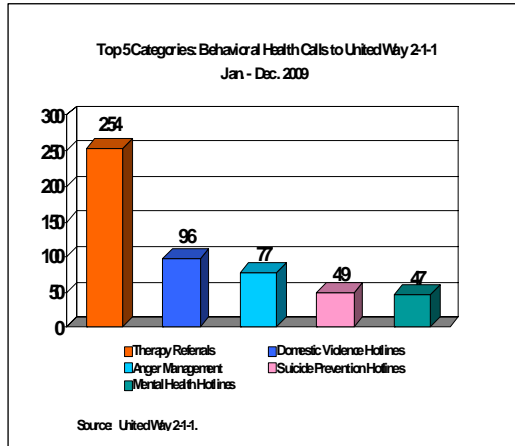


**C. Other Data**

## 1. United Way 2-1-1

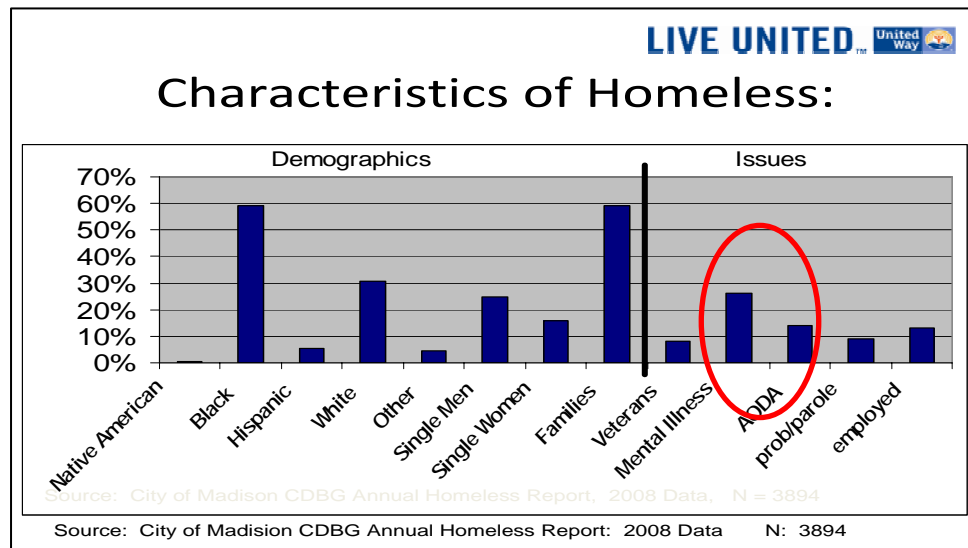
In 2009, United Way 2-1-1 had 826 calls for behavioral health-related questions. That is 1% of the total 73,000 calls received. 1,163 referrals were made – some calls were referred to several different places.

Most callers were looking for outpatient counseling or therapy.



## 2. Homeless and Offenders

In line with national trends, mental illness and to a lesser extent alcohol and substance abuse are seen in Dane County's homeless population. The 2008 Annual Homeless Report produced by the City of Madison's Community Development Block Grant Officer shows the following profile of homeless individuals:

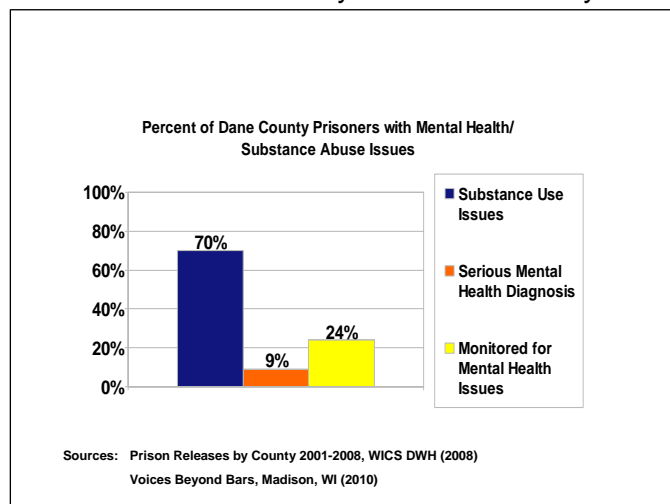


Nearly 30% have a mental illness and about half as many have a substance use problem.

A subset of 91 homeless individuals had more than 3 negative contacts with police over a 6 month period during 2007-2008. Sixteen of these “high contact individuals” were women. Seventy-nine percent of the total group was found to require treatment for either mental illness, substance abuse, or both.

### 3. Former Offenders

Also mirroring the national picture is the prevalence of mental health and substance use problems seen in offenders in our community. In 2008, 648 inmates returned to the community from Dane County correctional institutions. Nearly 80% of prisoners

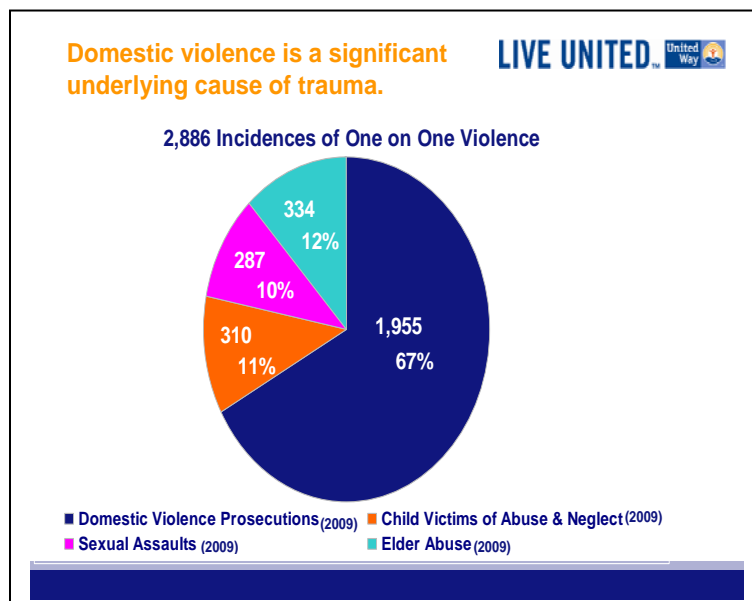
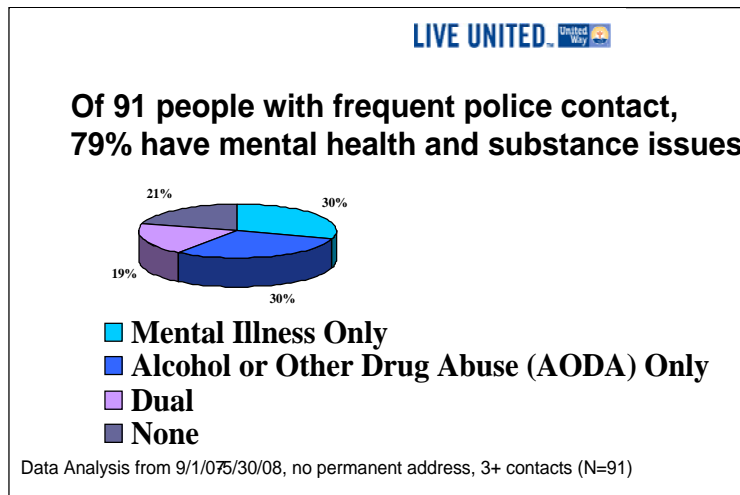


are returning with mental health, behavioral health, and substance abuse issues. Treatment and medications that were provided while the offenders were incarcerated are generally not available after they are released. The need to create better transitions to insure continuity of care was identified as a significant issue.

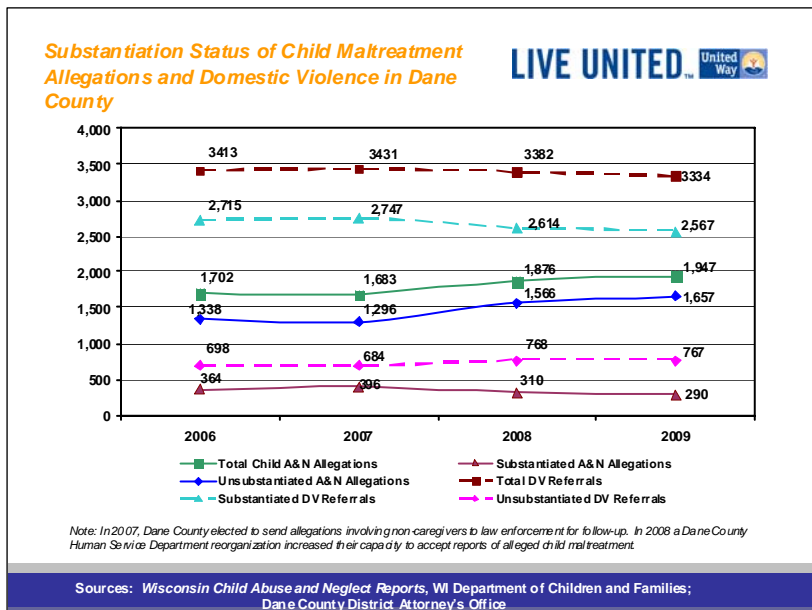
### 4. Trauma

There is no single data set or indicator that describes the true scope of trauma’s impact. We can understand potential triggers by looking at the frequency with which events such as sexual assault,

domestic violence, or even natural disasters occur, as a proxy for trauma. Many other sources such as hospital emergency departments, reports of auto accidents, and instances of bullying provide similar clues to trauma triggers. But what is not known is the extent to which traumatic events are experienced but never reported. We heard from a variety of professionals who work in law enforcement, healthcare, and human services fields that each day they deal with many people and situations where trauma is a major problem. Domestic violence is one of the largest factors that can lead to psychological trauma. In 2009 there were 290 substantiated allegations of child abuse and neglect in Dane County. (Note: Due to changes made in

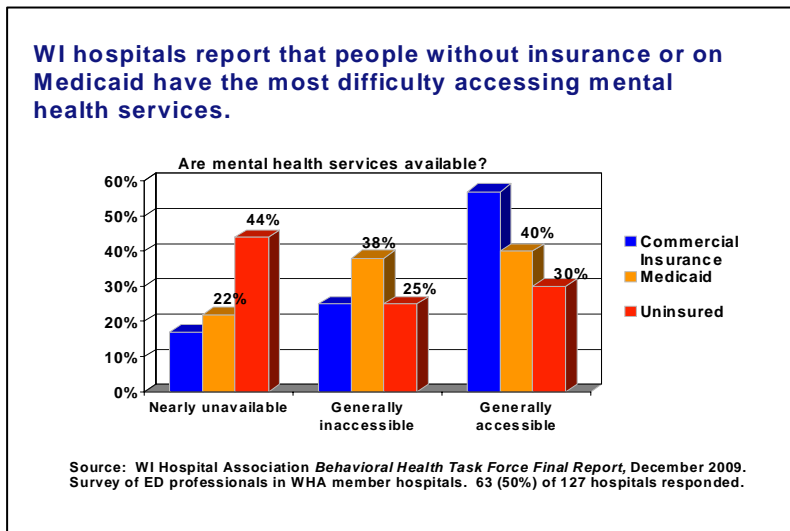


2007/2008 regarding how this data is reported comparisons with previous years' reports cannot be made.) There were 2,567 confirmed and 767 unsubstantiated domestic violence reports in Dane County in 2009 compared with 2,715 and 698, respectively, in 2006. Madison Police Officers have noted that domestic violence calls are among the most volatile and dangerous to which they respond. Law enforcement is very concerned about the number of children who witness violence in their homes.



### 5. Access to Care

In 2010 the Wisconsin Hospital Association's Behavioral Task Force published the results of a survey of Emergency Department personnel to gain an understanding of issues related to the accessibility and availability of mental health services in their communities.



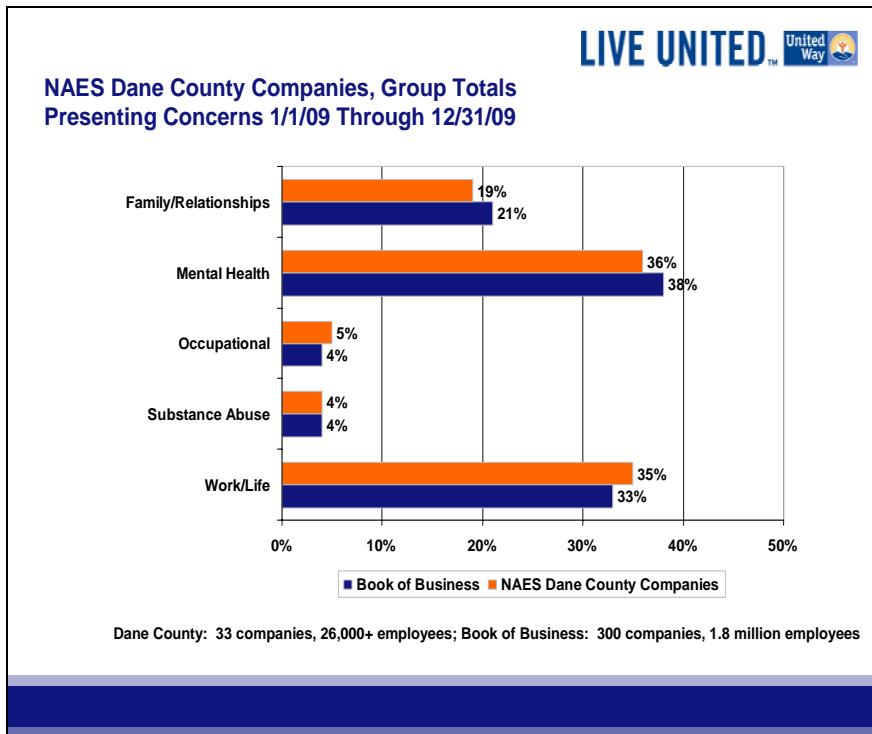
- 42% felt that mental health services were nearly unavailable or generally inaccessible for patients with Medicaid coverage.
- 60% had the same impression re: individuals with no insurance coverage.

### 6. Behavioral Health and the Workplace

Data describing the overall state of behavioral health in the Dane County workplace

is difficult to find. It is by nature sensitive and proprietary to employers and their insurers. We do have evidence that the issues people carry with them to work, and seek help for through their employer's employee assistance programs (EAP), are essentially the same in Dane County as throughout the rest of the country. The information shown here was prepared for the Delegation by NEAS (now Empathia, Inc.), a national company that provides EAP, workplace wellness and safety services to the business community. The top reason for contacting the EAPs was for help with mental health concerns such as stress, anxiety, or depression. Addiction-related concerns represent about 4% of total services provided, a number also reported by other EAP providers.





As a general rule, about 4-5% of employees utilize EAP programs where they are available, primarily for help with relationship and work-related issues. This is an underutilized resource. The stigma associated with behavioral health and difficulties inherent in educating employees about their use likely keep these from being top-of-mind resources when assistance is needed.

## B. Resources

There are three primary delivery channels in Dane County where

people seek help with mental and behavioral health concerns: our healthcare system; community-based non-profit providers; and therapists in private practices. We estimate that combined there are over 645 behavioral health providers with a broad range of expertise and specialization. Mendota Mental Health Institute, one of the state's psychiatric hospitals located in Dane County, serves indigent patients with severe mental illnesses from across the state.

### 1. Healthcare System

Dean Health System, Group Health Cooperative – SCW, Meriter Health Services, VA Hospital, UW Health, and Access Community Health Centers are the major providers of primary health care in Dane County. All provide some level of access to behavioral health care for their patients. Access Community Health Centers, a Federally Qualified Health Center, has adopted the fully integrated primary health/behavioral health care model. The other health systems are considering doing so or are already somewhere on the continuum toward a fully integrated model. (Note: Meriter Health System has recently entered the primary care arena.

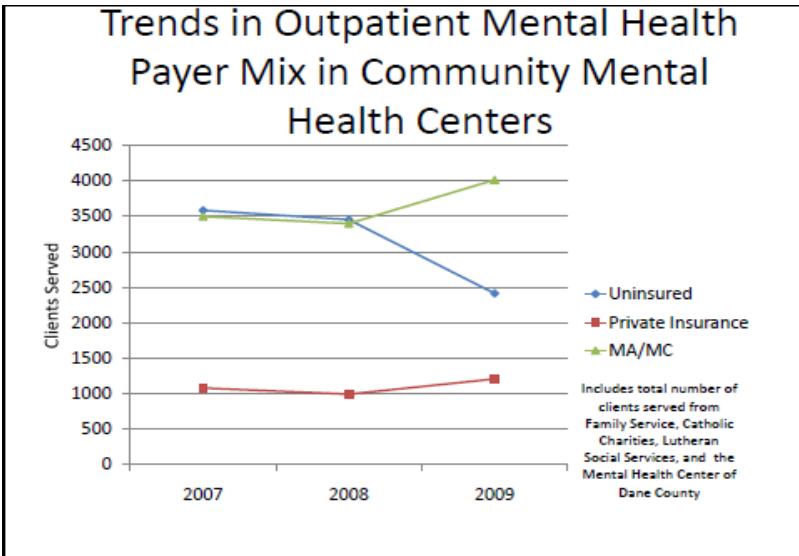
Meriter Health Service's 22-bed Child and Adolescent Psychiatric Hospital is the only community-based inpatient psychiatry program for children and youth in south central Wisconsin. They also offer a 16-bed inpatient unit for adults and operate NewStart, a comprehensive chemical dependencies rehabilitation program for adolescents and adults.

UW Hospital operates a 20 bed inpatient unit (including 2 seclusion rooms) for adults and occasional adolescents who need acute psychiatry care, safety and stabilization. St. Mary's Hospital also has a 22-bed inpatient unit for voluntary hospitalizations.

The Emergency Departments at all 3 hospitals also care for patients with behavioral and mental health problems which may or may not be the primary reason for seeking care.

A new 20 bed crisis stabilization resource is now available for individuals experiencing a behavioral health crisis who are not appropriate for inpatient care yet not stable enough to be in

an unsupervised living situation. The Mental Health Center of Dane County oversees the intake and referral of consumers to crisis stabilization beds provided by Tellurian and the Mental Health Center. This well-received hospital diversion program is funded by the county and third party payers.



## 2. Community-based Non-profit Providers

Licensed community-based non-profit mental health providers have historically provided the safety net for people seeking behavioral health treatment who lack insurance coverage or are otherwise unable to pay for it. These agencies typically serve a large number of individuals or families with incomes at or below the poverty level.

Treatment for behavioral health issues could be obtained because payment for therapy was based on a sliding fee scale tied to income level. Some paid the full cost of the session while others paid less. This was possible because providers were able to generate income through insurance, grants, and other revenue streams that subsidized the difference between full cost and what was actually paid for treatment.

This has changed dramatically over the past few years. Revenue generated through insurance reimbursement has been greatly reduced largely because the State contracts directly with Managed Care Organizations for healthcare for the Medicaid (i.e., low-income) population.

The major health providers in Dane County provide behavioral health services in-house and minimize referrals to outside providers in order to control costs. United Way of Dane County has redirected funding that had once been available for general counseling to trauma-specific services in 2011.

The loss of these funding sources has greatly reduced the capacity of these organizations to be the safety net behavioral health providers. The accompanying chart shows the dramatic drop in the number of uninsured clients served by the non-profit mental health providers in Dane County and the increasing reliance on insurance as a part of their payer mix.

## 3. Therapists in Private Practice

We have little information about accessing care through private providers. Without a centralized point for listing or obtaining information about providers and their areas of practice, accessing appropriate care, even for those with means to pay for it, can be problematic.

## 4. The Value of “No Wrong Door” to Care

The availability of many potential resources for help with behavioral and mental health concerns is an asset to our community. At the same time, the number of choices in providers and service locations can be overwhelming to the point where it stifles one’s ability to seek help when it is most needed. There is no centralized point of information and/or referral – a “Single Front Door” – in Dane County that facilitates linking those in need with an appropriate provider and level of behavioral health care. Developing navigational tools/processes such as multiple points of entry,



(i.e., “no wrong door”) to treatment has been identified as a needed improvement to Dane County’s behavioral health care system.

### C. Community Engagement

United Way of Dane County has a long history of bringing people and systems together to work on complex issues that impact and affect the human condition. The intent of our community engagement was to understand the far-reaching impacts of behavioral health on individuals, families, and the community, as well as the complexity of the issues at hand.



*MPD Officer Chanda Dolsen offers community leaders a look at behavioral health issues on State Street.*

A number of activities were arranged to give Delegation members an opportunity to see for themselves what they were learning at their monthly meetings. These ranged from field trips to State Street (walking the beat with the Madison Neighborhood Police Officer) or the Dane County Jail on a Friday night, to site visits to community resources that a person might use as they move from a behavioral health crisis through recovery, to informative conversations with mental health consumers and private behavioral health service providers. Delegation meetings provided an opportunity for specialists in various areas to add their research and expertise to the collective background and experience of those in the Delegation. This process allowed the Delegation members to fully discuss the issues from a variety of perspectives. (See Appendix E)

### What the Delegation Learned Through its Engagement Activities

1. Mental health stigma still exists and is a barrier to seeking help.
  - Integrating behavioral health and primary care helps remove this concern.
2. As is the case in most correctional facilities in our country, a high percentage of the inmates housed in the Dane County Jail have mental health and substance abuse problems. Only a portion of those individuals re-enter our community engaged with the services they need.
  - Treatment is provided, including access to a psychiatrist and medications.
  - The Madison Police Department has a well-trained force, including special Mental Health Liaison Officers, that approach situations where behavioral and mental health issues may be involved with understanding, care and compassion.



*Sue Janty, Meriter Hospital, and Gretchen Lowe, Community Leader, evaluate Dane County Jail's services for offenders with behavioral health problems.*

3. People with serious mental illnesses can recover. For some, recovery means they are able to go about their daily lives for years with few or no symptoms. For others, recovery means living rewarding, fulfilling lives while managing their symptoms with treatment and support.
  - Peer support programs are effective models that can speed and support this process.
  - The peer support model may be underutilized in our community.
4. Behavioral health and substance abuse problems need to be addressed concurrently.
  - Dane County's siloed funding and behavioral health/substance abuse service systems is a barrier to effectively treating dual diagnosis.
  - The system is hard to navigate and results in significant resources being devoted to case management instead of treatment.
  - Presently, there is little if any integration of treatment of these issues in Dane County.
5. Trauma is a major "root cause" trigger that underlies many behavioral health issues.
  - There are evidence-based treatment models that successfully help people recover from trauma.
  - Our service system here in Dane County is not fully "trauma-informed." That means that people seeking help may not receive the best type of help that allows them to move through the impacts of trauma successfully.

6. There are multiple cost and payment issues that limit access to behavioral health care.
  - Unlike medical insurance, there is no single standard benefit design insuring behavioral health care, even when parity laws are applicable.
  - CHANGE IS COMING between now and 2014 due to health care reform. The healthcare system will pay for behavioral health services that are medically necessary.
  - Trend in delivery is melding of health and behavioral health care into integrated model.
  - Mental health prevention: screening becomes more important



*Delegation members visit Porchlight's Safe Haven program which provides temporary housing and support of homeless men and women with mental illness.*



*Delegation Co-Chair Donna Katen-Bahensky, UW Hospital and Clinics, and member Angela McAlister talk with Safe Haven staff and clients.*

7. Disconnects and mismatched services lead to inefficiencies and poor treatment outcomes
  - Continuity of care is lacking when people who have been treated/stabilized in jail are released and come back into the community without connection to a mental health provider and medications.
  - "Failure" in multiple treatment settings is required before a person is matched with an intervention that works (*especially when behavioral health and substance use issues are involved*)
8. Our community lacks sufficient mental health treatment resources to adequately meet all needs. However, the treatment provider network has inefficiencies that, if resolved, would enable more people to be served.
  - We may too often default to treatment by providers (the "professional" model) when peer support may be less costly and more effective.

- Not all providers or organizations are appropriately equipped to treat patients with dual diagnoses.
  - Teams of primary care providers, psychologists and psychiatrists can serve more patients by working together than a single provider alone.
9. Research and evidence should inform treatment design and delivery. For example:
- Suicide: tailor intensity of care to times of highest risk to patient.
  - Exposure therapy for Post Traumatic Stress Disorder.
  - Mental health and substance abuse treated simultaneously.
10. Employers are important partners in helping people access help for behavioral health concerns.
- Workplace managers can be the conduit to help connect employees with EAPs if they understand that behaviors they are seeing may have a connection to an underlying behavioral health problem.
  - Employers can influence the benefit design of insurance products they purchase to include a behavioral health component.

## **VI. Hypothesis and Goal**

Stress and psychological trauma are a part of life, experienced by everyone to varying degrees, for various reasons, and with various outcomes across the life span. Significant traumatic experiences and the resulting psychological fallout are often at the root of problematic behavioral and mental health issues in children, youth and adults. While we can't keep "trauma" from happening, we can 1) attempt to prevent it, 2) promote a healthy response to it when it does occur (healthy survivorship), and 3) ensure that community resources are delivering trauma-informed and evidence-based services to those seeking help.

Research shows that the effects of trauma experienced in childhood can be reflected in unhealthy physical and emotional behaviors in adults if a healthy recovery from the event(s) has not occurred. This is of particular concern for adults who are parenting children. Unresolved trauma can impair their ability to parent effectively and create appropriate, healthy emotional relationships with others. It also means that all too frequently, the parents' own emotional issues/baggage must be addressed in the context of helping their child(ren) cope with behavioral and mental health concerns of their own. In this respect, then, "It all goes back to the family."

United Way of Dane County will focus on addressing the psychological impact of trauma on children, youth, and their families. We believe that doing so will help to minimize "bad outcomes" that children carry into adulthood (significant behavioral/mental health problems; criminal activity, substance use, etc.) and break the cycle of child abuse and neglect.

**Goal: BY THE EARLY IDENTIFICATION AND TREATMENT OF (STRESSORS AND) PSYCHOLOGICAL TRAUMA IN FAMILIES, WE WILL REDUCE THE INCIDENCES OF CHILD MALTREATMENT (ABUSE AND NEGLECT) IN DANE COUNTY TO 20% BY 2016 (REDUCING THE RATE OF SUBSTANTIATED CASES TO 10%).**

### **Target population:**

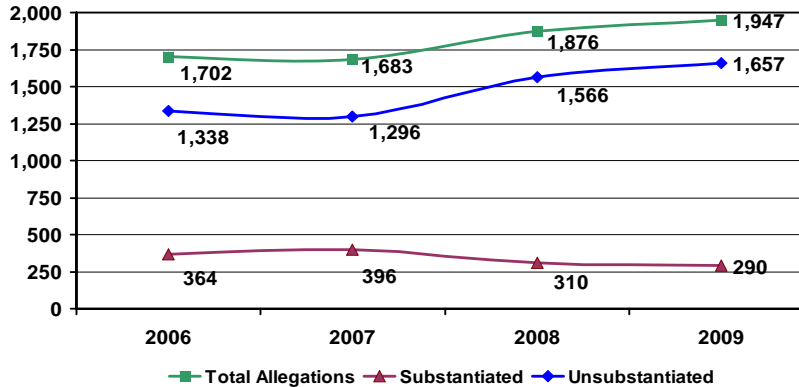
Families whose children have been identified in school setting needing treatment for trauma.

**Measurement:** Substantiated cases of child maltreatment (abuse and neglect) in Dane County.

**Reports of child maltreatment - substantiated AND unsubstantiated - are signs of family dysfunction (and trauma-producing events)**



**Substantiation Status of Child Maltreatment Allegations in Dane County**



Note: In 2007, Dane County elected to send allegations involving non-caregivers to law enforcement for follow-up. In 2008 a Dane County Human Service Department reorganization increased their capacity to accept reports of alleged child maltreatment.

Source: Wisconsin Child Abuse and Neglect Reports, WI Department of Children and Families

**VI. Strategies:**

- A. **Early identification of exposure to and effects of trauma:** CBITS, increasing system responsiveness to trauma survivors
- B. **Link trauma to treatment:** integration of behavioral health with primary care treatment
- C. **Implement research based, trauma specific and outcome-based treatment services:** training of human service providers, health providers, law enforcement, employers in best practices for trauma survivors (Note: This is a community-level strategy that is beyond the scope of United Way’s influence.)

**VII. Resources and Timeline**

Strategy	Tactics	Resources/Approach	Timeline
Early identification of exposure to and effects of trauma	Screen all 6 <sup>th</sup> graders in Dane County for trauma; provide CBITS intervention when appropriate	<ul style="list-style-type: none"> <li>▪ \$116,000 supports CBITS in 4 school districts</li> <li>▪ At-scale expansion throughout Dane County school districts</li> </ul>	2011  ???
	Add FACE-Kids Parent’s Component –Help parents understand how to prevent behavioral/mental health issues in children/youth from elevating to crises, trauma-producing events through use of evidence-based interventions	<ul style="list-style-type: none"> <li>▪ \$205,000 for FACE-Kids programs in K-12 schools across the County</li> </ul>	2011

Strategy	Tactics	Resources/Approach	Timeline
	Expand community-wide screening for trauma in adults	<ul style="list-style-type: none"> <li>▪ Determine feasibility of use of common screening question or tool across providers, or self screener available on a website</li> </ul>	2012
	Assure that early responders use trauma informed approaches/practices	<ul style="list-style-type: none"> <li>▪ Law enforcement and justice systems</li> </ul>	2013
	Create trauma-informed (health and) human services system	<ul style="list-style-type: none"> <li>▪ Train key service systems (children &amp; youth, health, shelter, community safety services) on trauma informed care</li> </ul>	2014
Connect trauma survivors with early, appropriate treatment	Trauma-informed United Way 211 has a comprehensive listing of resources for trauma recovery (& inventory of trauma-informed services in Dane County?)	<ul style="list-style-type: none"> <li>▪ 2-1-1 database can easily retrieve this information</li> <li>▪ Staff and volunteers trained in trauma-informed care</li> </ul>	2012??
	Develop easy-to-access tool/means to connect trauma survivors with the help they need at the right time, right place, and when they need it.	<ul style="list-style-type: none"> <li>▪ Trauma Assessment checklists or similar tool on UWDC website: <ul style="list-style-type: none"> <li>-- Parents to use for kids</li> <li>-- For adults</li> </ul> </li> </ul>	2011
	Implement researched, trauma specific and outcome-based treatment services	<ul style="list-style-type: none"> <li>▪ Target 2011 adult behavioral health dollars to trauma through Request for Proposal process</li> </ul>	<ul style="list-style-type: none"> <li>▪ June 2011</li> </ul>

### -Appendices

- A. Delegation to Improve Behavioral Health Members
- B. Health Council Members
- C. Delegation to Improve Behavioral Health Recommendations
- D. The Adverse Childhood Experiences Study Definitions
- E. Delegation to Improve Behavioral Health Community Engagement Activities Summary – Highlights



**Appendix A. Delegation to Improve Behavioral Health Members**

	<b>Delegation Members</b>	<b>Organization</b>
1.	Donna Katen-Bahensky President & CEO	UW Hospital & Clinics
2.	Dan Rashke CEO	United Way Board Member Total Administrative Services Corporation
3.	Carol Appleton Community Resource Specialist Volunteer	United Way 2-1-1
4.	Dr. Randy Brown Family Medicine	UW School of Medicine and Public Health
5.	Brian Cain President	Catholic Charities
6.	Dave Cieslewicz Mayor	City of Madison
7.	Kathryn Coleman Mental Health Coordinator, East Clinic	Group Health Cooperative
8.	Tom Crabb MS, LCSW Director of Mental Health	Dean Health System
9.	Dr. Dean D. Krahn Chief, Mental Health Services	Veterans Administration Hospital
10.	Michael Fox Government Programs Practice Leader	Dean Health Plan
11.	Lynn Green Director	Dane County Dept. of Human Services
12.	William Greer Executive Director	Mental Health Center of Dane County
13.	Dean Groth Managed Market Manager	Pfizer, Inc.
14.	Meg Groves Vice President of Program Services	Lutheran Social Services
15.	Rick Hafer, Ph.D. Clinical Vice-Chair of Psychiatry	UW Health
16.	Sue Janty Director of Behavioral Services	Meriter Health Services
17.	David Johnson President	Family Service, Inc.
18.	John Komosa Chief Operating Officer	QTI Human Resources, Inc.
19.	Dr. Dean D. Krahn Chief, Mental Health Services	Veterans Administration Hospital

	<b>Delegation Members</b>	<b>Organization</b>
20.	Bonnie Loughran, LCSW, LPC Executive Director	NAMI Dane County
21.	Sheriff David Mahoney	Dane County Sheriff's Department
22.	Ava Martinez Parent	NAMI Dane County
23.	Angela McAlister Interim Executive Director	WI Association on Alcohol & Other Drug Abuse
24.	Tess Meuer Director, Legal Department	WI Coalition Against Domestic Violence
25.	Amy Mosher-Garvey Therapist in Private Practice	Women & Families Psychological Services
26.	Brad Niebuhr Senior Account Executive/Partner	M3 Insurance Solutions for Business
27.	Lucía Nuñez Director	Department of Civil Rights
28.	Linda Oakley, PhD, RN Professor	UW Madison-School of Nursing
29.	Lauren Pallin Psychiatric Unit Director	St. Mary's Hospital
30.	Dr. Ken Robbins Medical Director	WEA Trust
31.	Dr. Martha (Molli) Rolli Department of Corrections	Dane County Medical Society
32.	Captain Steven Rogers	University Police Department
33.	Lieutenant Kristen Roman	Madison Police Department
34.	Mark Rudnicki CEO & Treasurer	Stevens Construction Corporation
35.	Neftali Serrano, PsyD Primary Care Psychologist	Access Community Health Centers
36.	Peg Smelser Vice President, Ret'd.	WEA Trust, Ret'd.
37.	Henry Young Assistant Professor	UW School of Pharmacy



## Appendix B. Health Council Members

	<b>Health Council Members</b>	<b>Organization</b>
1.	Leslie Ann Howard, <i>Chair</i> President and CEO	United Way of Dane County
2.	Jennifer Alexander President	Greater Madison Chamber of Commerce
3.	Donna Katen-Bahensky President & CEO	UW Hospital & Clinics
4.	Ken Loving, M.D. CEO	Access Community Health Centers
5.	Frank Byrne, M.D. President	St. Mary's Hospital
6.	Kathleen Falk Dane County Executive	Dane County
7.	William Greer Executive Director	Mental Health Center of Dane County
8.	Jeff Grossman, M.D. President & CEO	UW Medical Foundation
9.	Dean Groth Managed Market Manager	Pfizer, Inc.
10.	Daniel A. Nerad Superintendent	Madison Metropolitan School District
11.	Bobby Peterson Attorney	ABC for Health
12.	Dr. Martha (Molli) Rolli Mendota Mental Health Institute	Dane County Medical Society
13.	Craig Samitt, M.D. President & CEO	Dean Health System
14.	Thomas Schlenker, M.D. Director of Public Health for Madison and Dane County	Representing the Mayor of Madison
15.	Eric teDuits, D.D.S. Pediatric Dentist	Children's Dental Center of Madison
16.	Jim Woodward President & CEO	Meriter Health Services
17.	Larry Zanoni Executive Director	Group Health Cooperative of SC WI



## Appendix C. Delegation to Improve Behavioral Health Recommendations

### Background

The Delegation to Improve Behavioral Health was convened to examine whether the current configuration of behavioral health services – established over twenty years ago with the movement away from institutions to community-based care – effectively meets current needs. Specifically, there is concern that fragmentation and duplication in the system result in:

- gaps that hinder the continuity of care;
- inefficient use of existing resources;
- limits in service capacity; and
- an inability to adopt new best or promising practices.

### Scope and dimension of behavioral health in Dane County

The Delegation has seen that challenges created by behavioral and mental health issues are encountered to varying degrees in every area of our community. Based on national data, we estimate that nearly 105,000 (26%) of the 383,000 adults in Dane County experience behavioral health problems with depression and anxiety being the most prevalent affecting nearly 76,000. Another 16,700 children and youth under 18 also experience behavioral health problems. Even though we have over 645 mental health providers and a \$200+ million treatment system in Dane County, many people can only access treatment for behavioral and mental health care in Dane County through a high-cost back door such as the jail or hospitals' Emergency Departments instead of outpatient community resources. Behavioral health issues are also the second-leading cause of disability

### Recommendations

The Delegation to Improve Behavioral Health has developed recommendations around three key goals:

1. Improve timely access to appropriate mental health treatment/care through efficient capacity and utilizing evidence-based care practices.
2. Efficient use of existing capacity
3. Improving access to care

Our recommendations address the broad continuum of need, from easing access to care for those who are dealing with a short-term, transitional disorder to using different models such as peer support for people with severe and persistent mental illness who are on their way to recovery. The Delegation hopes its work stimulates health providers, funders, community agencies and others to re-examine their “traditional” approaches to service delivery in light of the growing body of evidence about what does – and doesn't – work.

These are the Delegation's **priority recommendations** for the Health Council:

1. *Integrate behavioral health screening/care into primary health care settings* – behavioral health specialists become part of the patient care team at the doctor's office and are available to see patients with mental health problems at the time of their doctor's visit. Improves access to treatment and medications, removes stigma, and generally leads to better outcomes for patients.
  - a. *Behavioral Intervention and Screening* – universal screening by interview or questionnaire conducted in primary care, emergency departments and hospitals to identify risk for problems with tobacco, alcohol and drug use and depression. Patients with positive screens are linked with immediate, brief interventions or referred for specialized treatment.
2. *Improve system navigation for matching patients to appropriate providers* – implement strategies that help people easily find and connect with timely, appropriate, and quality behavioral health care.
3. *Improve access to psychiatrists/health providers for appropriate medication services* – strategies like the integrated behavioral and primary health care model are helping to address this concern,

one of the most serious and frequently mentioned problems encountered in the Delegation's work.

**Other recommendations: Categorized according to effectiveness in addressing the problems (IMPACT) and likelihood of successful implementation (PROBABILITY)**

**HIGH IMPACT/HIGH PROBABILITY**

1. *Practice trauma informed care* – an approach to mental health treatment that factors in the current or delayed impact of trauma on the issue(s) at-hand and uses trauma specific therapy. (Note: United Way of Dane County has stepped forward and agreed to lead community work on this recommendation, in part because of its relationship to the United Way's work related to school aged-children and trauma).
2. *Integrate mental health and substance use treatment for co-occurring disorders* –treat patients who have both mental health and substance abuse problems for both issues simultaneously since they are often interrelated. Will require modification of policies and reimbursement practices that required separation between the two.
3. *Improve our community's response to and follow-up with people experiencing a mental health crises* – crisis intervention services in Dane County are of high quality when they are accessed by someone at-risk of harming themselves or others. Follow-up care is critical but extremely limited at present; strategies for improvement should be explored.
4. *Increase availability of peer support models for those with persistent and severe mental illness* – programs run by peers are often more effective in promoting recovery for people with serious and persistent mental illness than the traditional therapeutic, medical model.

**HIGH IMPACT/MEDIUM PROBABILITY**

5. *Develop viable and sustainable pathways to non-crisis mental health care for the uninsured* – people who are uninsured have the greatest difficulty obtaining help for mental health problems that are not "crisis" in nature. How can we connect these individuals with the care they need before a crisis situation develops?
6. *Drop-in treatment* – behavioral health services that can be accessed when needed – no appointment necessary. Referral to appropriate caregiver for future care.

**HIGH IMPACT/LOW PROBABILITY**

7. *Eliminate/reduce organizational payment barriers that prevent access to treatment* – insurance and managed care health plans typically restrict mental health care to a certain number of visits and certain providers regardless of a patient's individual needs.
8. *Treatment Courts: Drug/Operating While Intoxicated (OWI)* – provides treatment as an alternative to incarceration for people convicted of drug or OWI violations. Typically consists of a minimum year-long program during which time those undergoing treatment must remain sober, attend hearings and participate in support groups. La Crosse's OWI Court reports that 86% of people successfully completing this program have not had a repeat OWI offense.
9. *Facilitate the hand-off from jail or hospital emergency department (ED) to community provider* – develop process to assure that people who have received mental health treatment and medications while in jail or the ED continue to receive them and are connected with follow-up care upon release or discharge to the community.

10. *Use data to improve care* – collect and utilize data to provide population based care that identifies and targets the “dosage” of interventions to patient groups at the appropriate time. For example, evidence shows that veterans are at the highest risk for suicide when they first ask for help and/or medications are changed. More frequent office visits at these times can address these risks in a planned, cost-effective manner.
11. *Expand capacity through greater use of independent providers (therapists in private practice; community-based agencies, etc.)* – change reimbursement and referral practices that limit the ability of qualified independent providers to provide mental health care for certain populations (i.e., those insured through BadgerCare, HMOs, etc.) In conjunction with State of Wisconsin leadership, develop a demonstration project to provide a baseline impact. Must demonstrate that costs can be reduced and quality improved.
12. *Provide financial incentives with insurance coverage that pays for known/emerging best-practice treatment.* Employers who are self-insured are in the position to influence insurance products for their employees that are designed in this manner. This strategy requires a strong “business case” for best practices and service/health/treatment providers able to deliver care in this manner. Work with a small group of employers who are self-insured to present the case and provide data on the return on investment. Encourage employers to utilize their employee assistance programs to care for a broader group of patients.
13. *Eliminate/reduce stigma that prevents access to treatment* – the stigma associated with “having mental health problems” prevents many people from seeking treatment that could help them. Providing access to behavioral health care at the doctor’s office is an effective strategy for addressing this issue but more needs to be done to change public perceptions around. Community wide campaign developed and funded by a coalition of committed and interested organizations and individuals including governmental leaders, employers, health care providers, insurance providers

#### **LOW IMPACT/LOW PROBABILITY**

14. *Increase professional development for innovative and evidence-based work* – create opportunities for mental health practitioners to update their knowledge and skills about research-based practices such as trauma-informed care. Professional development should also be provided to primary care physicians and their staff to learn how to identify issues and to work with mental health providers in their respective primary care practices.
15. *Expand or increase flexibility in times that treatment services or referral services are available* – expand office hours or offer alternatives to the “9 to 5” office visit.





## Appendix D. Adverse Childhood Experiences Definitions

The following categories all occurred in the participant's first 18 years of life.

### Abuse

**Emotional Abuse** Often or very often a parent or other adult in the household swore at you, insulted you, or put you down and sometimes, often or very often acted in a way that made you think that you might be physically hurt.

**Physical Abuse** Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at you or ever hit you so hard that you had marks or were injured.

**Sexual Abuse** An adult or person at least 5 years older ever touched or fondled you in a sexual way, or had you touch their body in a sexual way, or attempted oral, anal, or vaginal intercourse with you or actually had oral, anal, or vaginal intercourse with you.

### Neglect

**Emotional Neglect**<sup>1</sup> Respondents were asked whether their family made them feel special, loved, and if their family was a source of strength, support, and protection. Emotional neglect was defined using scale scores that represent moderate to extreme exposure on the Emotional Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form.

**Physical Neglect**<sup>1</sup> Respondents were asked whether there was enough to eat, if their parents drinking interfered with their care, if they ever wore dirty clothes, and if there was someone to take them to the doctor. Physical neglect was defined using scale scores that represent moderate to extreme exposure on the Physical Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form constituted physical neglect.

<sup>1</sup>Collected during the second survey wave only (N=8,667).

### Household Dysfunction

**Mother Treated Violently** Your mother or stepmother was sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her and/or sometimes often, or very often kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over at least a few minutes or ever threatened or hurt by a knife or gun.

**Household Substance Abuse** Lived with anyone who was a problem drinker or alcoholic or lived with anyone who used street drugs.

**Household Mental Illness** A household member was depressed or mentally ill or a household member attempted suicide.

**Parental Separation or Divorce** Parents were ever separated or divorced

**Incarcerated Household Member** A household member went to prison.

## Finding your ACE Score

### While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often...**  
Swear at you, insult you, put you down or humiliate you?  
**Or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes No If yes enter 1 \_\_\_\_\_
2. Did a parent or other adult in the household **often or very often...**  
Push, grab, slap, or throw something at you?  
**Or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes No If yes enter 1 \_\_\_\_\_
3. Did an adult or person at least 5 years older than you **ever...**  
Touch or fondle you or have you touch their body in a sexual way?  
**Or**  
Attempt or actually have oral, anal, or vaginal intercourse with you?  
Yes No If yes enter 1 \_\_\_\_\_
4. Did you **often or very often** feel that...  
No one in your family loved you or thought you were important or special?  
**Or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No If yes enter 1 \_\_\_\_\_
5. Did you **often or very often** felt that...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**Or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No If yes enter 1 \_\_\_\_\_
6. Were your parents **ever** separated or divorced?  
Yes No If yes enter 1 \_\_\_\_\_
7. Was your mother or stepmother:  
**Often or very often** pushed, grabbed, slapped, or had something thrown at her?  
**Or**  
**Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?  
**Or**  
**Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_

**Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score.**



## Appendix E. Delegation to Improve Behavioral Health Community Engagement Activities Summary – Highlights

Date	Who	Method	Results – Highlights
05.11.10  06.03.10	DIBH members & consumers from <ul style="list-style-type: none"> <li>▪ Cornucopia &amp;</li> <li>▪ Porchlight/Safe Haven</li> </ul>	Lunch and Learn With Consumers: conversation with consumers re: their experiences, ideas and opinions about what does/doesn't work	<ul style="list-style-type: none"> <li>▪ Recovery is possible – and desired – for people with serious mental illness, in the same way that people are “recovering” from alcohol or other addictions.</li> <li>▪ Difficult to access private psychiatrist when needed, primarily for med management</li> <li>▪ Dane County Mental Health Center only takes cases that are considered “crisis” cases.</li> <li>▪ Self determination is a key component of treatment; not always the case here.</li> <li>▪ Peer support is the most effective, evidence-based model for helping consumers in crisis AND recovery.</li> <li>▪ Medication groups + peer support counseling could treat a lot more people more effectively.</li> <li>▪ Hospital diversion programs and “warm lines” work.</li> <li>▪ Housing, case management, transportation are needed supportive services</li> <li>▪ Mental health and AODA services <u>have</u> to be provided together</li> </ul>
05.20.10	United Way Key Club Committee volunteers	Presentation & discussion about the DIBH	<ul style="list-style-type: none"> <li>▪ Stigma and confidentiality concerns are major barriers to people seeking help through work sites</li> <li>▪ Employee wellness programs typically don't address mental health as an area of focus other than through offering Employee Assistance Programs. The exception is in cases where a crisis or major event has occurred that warrants making mental health follow-up available to affected employees.</li> <li>▪ Several Key Club members reported recently noticing their health providers asking stress/mental-health related questions as a routine part of the visit. This feels appropriate and is a trusted place to talk about these issues.</li> </ul>
06.04.10	DIBH & UWDC Board members	State St. tour w/MPD Officer Chanda Dolsen	<ul style="list-style-type: none"> <li>▪ Madison Police Department has a well-trained force that approach situations where behavioral &amp; mental health issues may be involved with understanding, care and compassion.</li> <li>▪ Overture Center and the Downtown Library have established standards of behavior that define when someone is/isn't welcome in the facility.</li> <li>▪ Police Officers know the issues and people who frequent State Street well.</li> <li>▪ Problems attributed to behavioral health issues have been minimized on State Street through a combination of (police) educating business owners, environmental design, and pro-active, personalized problem solving by police officers.</li> </ul>
06.04.10	DIBH & UWDC Board members	Spend a few hours at Central Booking at the Dane County Jail on a Friday night.	<ul style="list-style-type: none"> <li>▪ Intake process at Central Booking includes medical and mental health assessment. Those that do not pass are sent to a hospital for “medical clearance” before accepted into jail.</li> <li>▪ Medical facilities provide pharmaceuticals for physical and behavioral health. Verifies prescriptions so that jailee can remain on prescribed treatment.</li> <li>▪ A new Discharge Planner is to insure release's have a destination and basic needs met. Are connected to medical and mental health providers upon discharge. Provided with limited amount of pharmaceuticals.</li> <li>▪ Mental health professionals also on the tour noted that officers are using same skills as psychiatric nurses.</li> <li>▪ Alcohol-related behaviors are largest reason for jailing (80%+).</li> <li>▪ Mandatory arrest laws require officers arrest (most)</li> </ul>

Date	Who	Method	Results – Highlights*
06.07.10	DIBH & UWDC Board members	Bus tour of six community resources that a person might use as they move from a behavioral health crisis through recovery	<ul style="list-style-type: none"> <li>▪ Dane County has a broad range of behavioral &amp; mental health resources, from the deep-end placement of last resort, to peer-run programs.</li> <li>▪ Demand for most services exceeds the capacity.</li> <li>▪ Medical Assistance funding is decreasing this year due to a shift in State funding policy. This has been an important revenue source for Mendota Mental Health Institute. Consequently, the County must pay a higher portion of the costs of this most expensive treatment option.</li> </ul>
08.26.10	DIBH members	Visit Dane County's Detox Center. See the facility and learn what happens when someone is taken to "Detox."	<ul style="list-style-type: none"> <li>▪ 5,000 admissions per year</li> <li>▪ Locked facility, most residents brought in by law enforcement under protective placement. Some are voluntary detox.</li> <li>▪ Protective placements must meet 4 criteria to leave; voluntary residents can leave at any time.</li> <li>▪ Length of admission is generally 12-72 hrs.</li> <li>▪ Detox capacity is 27 with average nightly census of 12-14.</li> <li>▪ Posted cost of care is \$395.00 per day.</li> </ul>
09.14.10	DIBH members & therapists in private practice	Connect behavioral health providers in private practice into our work through facilitated group discussions that explore their perspectives and ideas about being part of the solution to our concerns.	<ul style="list-style-type: none"> <li>▪ Private providers value opportunities to collaborate and be a part of a multi-disciplinary, cross-system team working toward a common goal for clients</li> <li>▪ Their concerns about the mh system are rooted in a patient-centered approach – what is/isn't working for the clients/patients they see</li> <li>▪ Accessing psychiatric care is a problem</li> <li>▪ Many do accept MA clients; frustrated with MA rules that are barriers to care <ul style="list-style-type: none"> <li>- Won't pay for services of a licensed counselor not associated with a clinic</li> </ul> </li> <li>▪ Feel locked out by HMOs <ul style="list-style-type: none"> <li>- Don't understand why panels are closed &amp; not open to conversations about partnership</li> <li>- Perception that HMOs don't provide access to specialty mh care -- grievance process can delay access by 6 months or more</li> </ul> </li> <li>▪ Meeting with HMO &amp; health system</li> <li>▪ Move from a "medical pathology" to a "wellness" model</li> <li>▪ Three wishes: <ul style="list-style-type: none"> <li>- Open access – no panels, each client can access qualified resources anywhere</li> <li>- Conversations between HMOs and private practitioners to build working relationships/new partnerships <ul style="list-style-type: none"> <li>× Further the understanding of each perspective</li> <li>× Explore opportunities to work together</li> <li>× Look for win/win/win (patient/HMO/private provider)</li> </ul> </li> <li>- Need a "matchmaker" that connects the person needing help with an appropriate provider <ul style="list-style-type: none"> <li>× Private providers having open appointments that are readily available to HMOs for referrals</li> <li>× Knowing which providers take MA patients</li> </ul> </li> </ul> </li> </ul>