

**Wisconsin Public Health Council
State Health Plan Committee**

**Final Report (January 2009)
Progress Report: Healthiest Wisconsin 2010
Health Priority: Mental Health and Mental Disorders**

Part I: Introduction

Addressing the mental health needs of Wisconsin consumers remains a priority. Approximately one in seven Americans will suffer from major depressive disorder. According to the National Committee for Quality Assurance and National Institutes of Health 2007 State of Health Care Quality Report, major depressive disorder is the leading disability in the United States.

In the Wisconsin public mental health system, the number of encounters statewide was approximately 196,634 in 2005; note that clients served in the private sector are not included in this number. Public service recipients are reported to the State through the Human Services Reporting System and Medicaid data systems, which include some duplication of clients. To date, no coordinated agreements have been made by these systems to retrieve, share, and compile unified data.

According to the National Surveys on Drug Use and Health (2004-2005), Wisconsin adults experienced serious psychological distress (SPD) “in the past year” at a rate of 11.8%, which resulted in Wisconsin ranking 25th highest in the nation for reported SPD. Additionally, 8.4% of Wisconsin adults experienced a major depressive episode (MDE) in that same period, compared to the national average of 7.6%; this resulted in Wisconsin ranking 15th highest in the nation overall, for major depressive episodes. These numbers indicate that Wisconsin is at the national average for SPD and has a higher rate of major depressive episodes than the national average.

However, through a partnership between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), the Wisconsin Behavioral Risk Factor Survey (BRFS) included questions on depression and serious psychological distress in 2006 and 2007, respectively. The BRFS assesses more recent experiences with SPD and depression (past 30 days). The 2006 data indicate that the overall Wisconsin prevalence rate for depression was 7% and the estimated prevalence rate for SPD in 2007 was 3%. This suggests that there may be a difference for responders when asked about past year experiences compared to experiences specific to the last 30 days. In the future, consistent use of one measure with national comparisons is recommended for ease of evaluating Wisconsin's performance.

Data collected for 2004-2005 via the Mental Health/Alcohol and Other Drug Abuse Functional Screen, a Wisconsin-based screen that measures levels of need within Wisconsin's major programs for mental health consumers with a serious mental illness (SMI), revealed that of those who had co-occurring mental health and substance abuse diagnoses, higher than average rates of inpatient stays, criminal justice system involvement, suicide attempts, and homelessness were

reported. Of adults with SMI, only 28% were employed (Human Services Reporting System, 2005). In addition, 7% of adults with SMI and 20% of youths who reported a serious emotional disturbance were arrested in the past year (Mental Health Statistics Improvement Program, 2006). Untreated mental illness in Wisconsin appears to be highly correlated with socio-economic difficulties across the lifespan, with physical health also suffering, including a life expectancy loss of 20% fewer years of life expected.

Youth in Wisconsin aged 12-17 years reported experiencing a Major Depressive Episode (MDE) in the past year at a somewhat higher rate than the national average (9.6% vs. 8.8%, respectively). Wisconsin's national rank for youth MDE prevalence is 11th highest. The youth depression rate in 2005 increased slightly from the 2003 rate. The 2005 rate of female youth depression was significantly higher than for males (33.3% vs. 22.2% respectively). The youth depression rate seems closely tied to the rate of completed youth suicide for Wisconsin, which is currently ranked the 8th highest in the nation. The 1999-2003 youth suicide rate for 15-19-year-olds in Wisconsin was higher than in surrounding states (10.9 per 100,000 population aged 15-19 in Wisconsin, compared to 10.6 in Iowa, 9.4 in Minnesota, 8.3 in Indiana, 7.8 in Michigan, and 6.1 in Illinois).

Social and economic factors are correlated with frequent mental distress (FMD) among Wisconsin adults, versus those without FMD. Approximately one-quarter of Wisconsin adults with FMD earned an annual income less than \$20,000 in 2004. Approximately one-third of those with FMD had poor health or health-related problems such as obesity and/or smoking. FMD was reported by 15% of adults who had attained less than a high school level of education, compared with just 5% of adults with a college degree (Wisconsin Behavioral Risk Factor Survey, 2004; Bureau of Health Information and Policy, 2004; Division of Public Health, 2004; Department of Health and Family Services, 2004).

Nationally, exposure to a traumatic event (e.g., sexual abuse) has also been shown to be significantly correlated to mental health diagnoses, poorer health, and risk for substance abuse and addiction. Given the rates of serious mental illness for certain segments of Wisconsin's population (e.g., female youth depression, American Indian female depression), the likelihood of a correlation between lifetime trauma exposure and poorer mental health in Wisconsin is high. This co-occurrence of trauma and poorer mental health is also a risk factor for vulnerability to poverty, homelessness, and socio-economic marginalization.

A major contributor to Wisconsin's average or below average ranking on many mental health and mental disorder indicators and health disparities overall is likely due to barriers to access to adequate health care including mental health care. One of the major barriers to access is lack of equitable health insurance, especially regarding the unemployed and marginalized populations.

Efforts towards reducing the health disparities for mental health consumers in both primary and other mental health care facilities (e.g., private practice and community-based health clinics) should include enacting insurance parity for all, supported by private and public partnerships, in an effort to combat financial barriers to access in mental health care. In addition, addressing issues of reimbursement will allow more providers to serve those afflicted with depression. The present reimbursement model results in less than 50% of service costs being covered.

Limitations to the evaluation of progress on Healthier Wisconsin 2010 Mental Health and Mental Disorders objectives include a lack of consistent access to services by financial, geographical, and cultural demographics, limitations related to data sources, a lack of consistent and coordinated tracking of all marginalized populations (e.g., Lesbian, Gay, Bisexual, Transgender-LGBT), and the lack of integrated services, work force training/education, and consistent identification of mental health needs across all health fields.

A primary finding of this report is that there has been no measured change in key mental health indicators. This suggests a need for the use of available specific and objective measures. If these measures are not available they should be developed. These data need to be collected and stored in a manner that allows for access to enable them to be monitored and reported on annually.

Part II: Progress in Achieving the Healthiest Wisconsin 2010 Long-Term Outcome Objectives

Objective I—Stigma Reduction

By 2010, 80% of State-administered employee group health plans, Medicaid-funded programs, BadgerCare, and Supplemental Security Income (SSI) managed care will, by contract, incorporate questions for mental health problems into their screening and referral processes.

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible. As of November 2005, none of these health plans or programs required screening for mental health problems despite data being gathered and available from Department of Health and Family Services, Mental Health and Substance Abuse Services, and Department of Public Health.*

Performance Status: No change

Objective II—Discrimination/Anti-Stigma

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

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Objective III: Cultural Competence

By 2010, 87% of the publicly funded mental health consumers will feel their service provider was sensitive to their culture during the treatment planning and delivery process.

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Objective IV: Access to Care

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

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

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Part III: Recommendations

1. **Create a uniform system for tracking mental health data.** This will require forming a data-sharing agreement between the Division of Public Health and the Division of Mental Health and Substance Abuse Services (DMHSAS). This will result in a uniformly available system for proper tracking and reporting of mental health data. The data-sharing agreement should include provisions to avoid present client duplication. This system should have the ability to retrieve and compile the data currently omitted for private sector clients and other marginalized groups to accurately reflect Healthiest Wisconsin 2010 objectives.
2. **Collect data and select indicators that address access and mental health outcome data.** These data should include youth depression and suicide, women and postpartum depression, marginalized populations, particularly Latino/Hispanic, American Indian/Alaska Native (distinguishing between urban, rural, and Tribal communities with consideration for the nation-wide trend of living off-reservation), gay, lesbian, bisexual, transgender persons, and the elderly, as well as intersections of the aforementioned populations. These data should include evidence based on recovery outcomes programs and potential for recovery. ***Additionally, clients served in the private sector need to be included.*** Such efforts would greatly benefit from the continuous inclusion of the Behavioral Risk Factor Survey (BRFS), Youth Risk Behavior Survey (YRBS), National Committee for Quality Assurance (NCQA) data, Health Effectiveness Data and Information Set (HEDIS) reporting, and the National Health Survey. Community-based methods for over-sampling marginalized populations, with a conscious sensitivity to utilize the most productive means of gathering personal data, and solid training for professionals for the implementation of same should be utilized. Finally, an overall focus is needed on gathering mental health data for alcohol and drug abuse, traumatic exposure, sexual abuse and depression (especially with American Indians) in a culturally competent manner.

3. **Enact insurance parity for all.** This should be inclusive of private and public services, in an effort to combat financial barriers to access in mental health care, with diligent consideration of the unique needs of Tribally enrolled persons living in off-reservation settings, given that more American Indians live in urban settings than on reservations in Wisconsin and nationally, with American Indian women hospitalized for depression in Wisconsin at a rate significantly higher than any other race/ethnicity. Special efforts towards reducing the health disparities for mental health consumers in both primary and other mental health care facilities (e.g., private practice and community-based health clinics) will facilitate this process. In addition, address issues of reimbursement (e.g., systems of reimbursement of uninsured/under-insured people, which results in less than 50% of service costs being covered).

4. **Develop private and public partnerships for creating a funded comprehensive “Combat Mental Health Stigma” marketing campaign.** This campaign should consider professional health education models suited for grassroots, private, and community-based public health outreach and outcome evaluation with considerations for marginalized populations.

References

Behavioral Risk Factor Surveillance System (BRFSS)

- <http://www.cdc.gov/brfss/>

Bureau of Health Information and Policy, 2004

- <http://dhs.wisconsin.gov/stats/BRFS.htm>

Department of Health and Family Services, 2004

- <http://dhs.wisconsin.gov/>

Division of Public Health, 2004

- <http://dhs.wisconsin.gov/tobacco/pdffiles/2004WiYTSMiddleSchool.pdf>

Human Services Reporting System

- <http://dhs.wisconsin.gov/hsrs/index.htm>

Medicaid data systems

- http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/01_Overview.asp

Mental Health/Alcohol and Other Drug Abuse Functional Screen

- <http://dhs.wisconsin.gov/lcarea/OtherLinks/MHAODA/MH-FAQ.HTM>

Mental Health Statistics Improvement Program, 2006

- <http://www.mhsip.org/sremhs/>
- <http://www.mhsip.org/srcmhs2006.htm>

National Committee for Quality Assurance and National Institutes of Health 2007 State of Health Care Quality Report

- <http://www.ahrq.gov/qual/nhqr07/Chap1.htm>

National Surveys on Drug Use and Health (2004-2005)

- <http://oas.samhsa.gov/nsduh.htm>

Wisconsin Behavioral Risk Factor Survey, 2004

- <http://dhs.wisconsin.gov/stats/pdf/BRFSQualityofLife.pdf>
- <http://dhs.wisconsin.gov/stats/BRFS.htm>