I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

State SAPT DUNS Number

Number
036448835

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name
Department of Health Services

Organizational Unit
Division of Mental Health & Substance Abuse, Bureau of Prevention, Treatment and Recovery

Mailing Address
1 W. Wilson St., Rm 850

City
Madison

Zip Code
53703

II. Contact Person for the SAPT Grantee of the Block Grant

First Name
Joyce

Last Name
Allen

Agency Name
Department of Health Services Division of MH& S A, Bureau of Prevention, Treatment and Recovery

Mailing Address
1 W. Wilson St., Rm 850

City
Madison

Zip Code
53703

Telephone
608-266-1351

Fax
608-266-1533

Email Address
joyce.allen@wisconsin.gov

State CMHS DUNS Number

Number
036448835

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

Department of Health Services

Organizational Unit

Division of Mental Health & Substance Abuse; Bureau of Prevention, Treatment and Recovery

Mailing Address

1 W. Wilson St.

City

Madison

Zip Code

53703

II. Contact Person for the CMHS Grantee of the Block Grant

First Name

Joyce

Last Name

Allen

Agency Name

Department of Health Services; Division of MH/SA; Bureau of Prevention, Treatment and Recovery

Mailing Address

1 W. Wilson St., Rm 850

City

Madison

Zip Code

53703

Telephone

608-266-1351

Fax

608-266-1533

Email Address

joyce.allen@wisconsin.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/30/2013 12:18:20 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Ryan

Last Name

Stachoviak

Telephone

608-261-9316

Fax

608-267-7793

Email Address

Ryan.Stachoviak@wisconsin.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

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Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
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13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: Kevin E. Moore Date: 8/20/13

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: Kevin E. Moore Date: 8/28/13

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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Name of Chief Executive Officer (CEO) or Designee: Kevin E. Moore

Title: Deputy Secretary

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary-Elect

March 13, 2013

Mike Huebsch, Secretary
Wisconsin Department of Administration
101 East Wilson Street
Madison, WI 53703

RE: Delegation of Signature Authority

Dear Secretary Huebsch,

As Agency Head and in accordance with the provisions of s.15.02(4), Wis. Stats, I hereby delegate signature authority to the following individuals for the particular documents indicated.

Kevin E. Moore, DHS Deputy Secretary
Andrew Hitt, DHS Executive Assistant

- ✓ Requests for Purchasing Authority
- ✓ Requests for Granting Authority
- ✓ Contracts entered into by any DHS organizational unit
- ✓ Memoranda of Understanding entered into by any DHS organizational unit
- ✓ Agreements entered into by any DHS organizational unit
- ✓ Grant Applications Submitted and Grant Awards Received

I will file updates to this list should there be a change in personnel in the delegated positions, when the level of specific delegation expands or contracts, or at any other time conditions warrant. Should you have questions regarding this transaction, please feel free to contact me.

Sincerely,

Kitty Rhoades
Secretary-Elect

CC: Rick Hughes, Director, State Bureau of Procurement, DOA
Kevin E. Moore, Deputy Secretary, DHS
Andrew Hitt, Executive Assistant, DHS
Cheryl K. Johnson, Deputy Administrator, Division of Enterprise Services, DHS
Jacqueline Sommers Smith, Bureau of Strategic Sourcing, DES, DHS

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

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Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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Name of Chief Executive Officer (CEO) or Designee	Kevin E. Moore
Title	Deputy Secretary

Signature of CEO or Designee[1]: _____ Date: _____

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Name of Chief Executive Officer (CEO) or Designee: Kevin E. Moore

Title: Deputy Secretary

Signature of CEO or Designee[1]: Kevin E. Moore Date: 8/28/13

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State of Wisconsin
Department of Health Services

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March 13, 2013

Mike Huebsch, Secretary
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CC: Rick Hughes, Director, State Bureau of Procurement, DOA
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I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Kevin E. Moore
Title	Deputy Secretary
Organization	Department of Health Services

Signature: Kevin E. Moore Date: 8/28/13

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Section II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Wisconsin has a state-supervised, county-based system of mental health and substance abuse (MH/SA) system. The Division of Mental Health and Substance Abuse Services (DMHSAS) in the Department of Health Services (DHS) is the state MH/SA agency and is the designated State Mental Health Authority (SMHA) and Single State Agency (SSA) for Substance Abuse. The division is responsible for allocating state and federal funding for the provision of MH/SA services and for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, more commonly referred to as state administrative code Chapter 51. While the state has broad responsibility for MH/SA system planning, management and oversight, the state's counties are statutorily responsible for administering MH/SA services. Wisconsin statutes further provide for counties to meet MH/SA service responsibility through single county systems, such as single county boards and departments of community programs or human services, or through multi-county systems.

Wisconsin utilizes a collaborative approach to ensure the monitoring of mental health and substance abuse prevention and treatment services through regionally based department staff, county based alcohol and other drug abuse coordinators, and contract administrators within DMHSAS. Wisconsin's regions include Northeastern, Northern, Southeastern, Southern, and Western and are comprised of the 72 counties and 11 Native American Indian Tribes. DMHSAS staff conducts annual site visits to provider entities to review progress and offer technical assistance as necessary. Moreover, the Division has a cooperative and productive relationship with Prairielands Addiction Technology Transfer Center and with the Center for the Application of Prevention Technologies. Both organizations are responsive to technical assistance requests and proactively involve DMHSAS in emerging trends in Wisconsin.

Wisconsin's public MH/SA services are funded through five primary sources:

- Medical Assistance (i.e., Medicaid)
- Federal Block Grants (community mental health services block grant and the substance abuse prevention and treatment block grant)
- Community Aids (funds social service, developmental disabilities, and MH/SA service programs)
- County Revenues (primarily county property tax revenues)
- Private Insurance or Individual Payments

Wisconsin's Mental Health and Substance Abuse System

Mental Health Services
As noted above, county mental health providers use county tax levy dollars to fund a portion of the services they deliver. State and federal tax dollars are also used to fund a portion of mental health services for public consumers. The largest source of federal funds for the provision of mental health services is through the Medicaid program. In Wisconsin most mental health Medicaid recipients are served through the Badger Care and SSI managed care programs. While 111,081 consumers were served through the fee-for-service program in 2011, another 127,030 were served through the two major Medicaid managed care programs. As a consumer's Medicaid status may change throughout the period of a year and program coverage policies have limitations, some consumers may use benefits through both programs to get the services they need. As of 2011 8.5% of consumers in the managed care programs also received some amount of fee-for-service benefits.

Psychiatric Hospitalization
When psychiatric hospitalization is required in Wisconsin it occurs in one of the following five settings: state mental health institutions, county mental health hospitals, veteran's administration hospitals, private psychiatric hospitals, and general medical/surgical hospitals. DMHSAS has administrative management of the two state mental health institutes: Mendota Mental Health Institute (MMHI), in Madison, and the Winnebago Mental Health Institute (WMHI), near Oshkosh. These facilities provide specialized, acute treatment to children and adolescents, adults, older adults and forensic mental health consumers. The institutions provide training and consultation as requested to community-based programs. As an arm of the MMHI, the founding model Program for Assertive Community Treatment (PACT) is in operation, serving Dane County.

Counties have a general statutory responsibility and a fiscal incentive to provide comprehensive community programs given that counties are responsible for the cost of care and treatment of persons who have a mental illness and are indigent. Clients between the ages of 22 and 64 admitted to a private, county, or state psychiatric hospital of more than 16 beds are not covered by Medicaid due to the Institute for Mental Disease (IMD) exclusion. Because of this, counties are responsible for the costs of treatment of an indigent patient's care in those facilities.

The State Correctional system also provides mental health services to some of its supervisees. In the adult correctional facilities across the state, State Corrections officials reported approximately 7,800 clients received mental health services at any one point throughout 2012. It is estimated an annual turnover rate in mental health caseload of one-third which leads to an estimated 10,400 adults receiving mental health services in the Wisconsin correctional system annually. In 2012 an estimated 450 of 662 (68%) males and all of the 72 females residing in one of the two juvenile correctional facilities in Wisconsin, received mental health services.

The Wisconsin public mental health system emphasizes the importance of treatment services being available at the community level in the least restrictive environment. The community mental health system strives to provide an array of services to consumers in an effort to reduce the need for inpatient treatment and reduce the disruption hospitalization can cause to the consumer and their family. Discharge planning and a strong aftercare community mental health system are required to be initiated on the day of a consumer's admission. Such planning is essential to ensuring the length of the hospital stay is kept at a minimum, assuring minimal re-admissions, and promoting recovery.

Substance Abuse Prevention and Treatment Services
Wisconsin provides a continuum of substance abuse prevention and treatment services. The DMHSAS within the Wisconsin DHS has several mechanisms in place to ensure that substance abuse services are effective and efficient. As with mental health services, Wisconsin operates under a State-supervised, county-administered substance abuse prevention and treatment service system. The management and oversight of traditional government responsibilities and services are vested at the municipal and county level of government.

Wisconsin Statute 51.01 identifies the Legislature's intent and public policy that a full range of treatment and rehabilitation services exists for alcoholism and other drug abuse. Under Wisconsin Statute 51.03, "Department Powers and Duties," the DHS is responsible for promotion of fiscal stewardship in the provision of substance abuse services. DHS is also responsible for ensuring that providers of substance abuse services develop, maintain, and evaluate their plan to address substance abuse needs and adhere to DHS 75, Community Substance Abuse Service Standards.

Under Wisconsin Statute 51.42, county governments have the responsibility to develop and manage a system of care for persons with substance use disorders. This includes the preparation of a local short-

and long-range plan to address substance abuse treatment needs, maintain oversight of the planning process, and maintain an inventory of existing resources. These county agencies are required to report the National Outcomes Measures (NOMS) data, both prevention and treatment data, through Wisconsin's Human Services Reporting System (HSRS) which populates the Treatment Episode Data Set (TEDS) and the Substance Abuse Prevention Service Information System (SAP-SIS) which are used for accountability purposes. The reporting of both the prevention and treatment NOMS are a contractual requirement with providers. Direct grants awarded from the State to private, non-profit and county agencies are also subject to performance management. Direct grant agencies are required to set performance objectives and report on progress on a semi-annual basis. DMHSAS contract administrators review these semi-annual reports and use the information to provide technical assistance and make contractual modifications as needed. Contract administrators also perform annual site visits to provider agencies to ensure programmatic compliance and offer technical assistance as necessary.

Substance Abuse Service Modalities
An array of traditional community substance abuse services are available to residents of Wisconsin through the County-operated system. These services include inpatient, detox-medically managed, detox–medically monitored or residential, residential primary-short term, residential transitional-long term, day treatment, outpatient-intensive, outpatient-regular, case management and prevention. The majority of service admissions are outpatient (70%), followed by detox (15%), residential (10%), day treatment (3%) and inpatient (1%). Over 55,000 persons in Wisconsin receive these vital services annually.

Special Substance Abuse Service Programs
The goal of the Wisconsin Strategic Prevention Framework State Incentive Grant (SPF-SIG) is to build state and local infrastructure in order to reduce: 1) underage drinking among individuals between the ages of 12 – 21; 2) young adult binge drinking among individuals between the ages of 18 – 25; 3) alcohol related motor vehicle fatalities and injuries among individuals between the ages of 16-34. Annually, $1.8 million in funding was awarded to 20 community coalitions who were selected using a competitive request for proposals process. Over half a million Wisconsin children and adults received some form of substance abuse prevention awareness, education or other activity and 93% of Wisconsin youth reported hearing, reading or watching an advertisement about the prevention of alcohol or other drug use.

The Alliance for Wisconsin Youth (AWY) is a program of the Wisconsin DHS, DMHSAS, in the Bureau of Prevention, Treatment and Recovery (BPTR) funded by the SAPT block grant. The Alliance's purpose is to enhance and support the capacity of grassroots community member coalitions to conduct substance abuse prevention and youth development. Over 100 Wisconsin coalitions are members of the Alliance, covering virtually every county. The AWY, in conjunction with local and national partners, and through its network of state AWY member coalitions, provides leadership, coordination, and communication to its members and to members of the prevention field through the following:

- Encouraging and empowering communities to organize local grassroots alliances.
- Establishing and facilitating a statewide network of local alliances to share information about evidence-based and emerging programs, practices and policies, and the resources to develop and implement these strategies.
- Linking local alliances to information about state and national prevention and youth development resources and the national network of community coalitions.
- Increasing state agency cooperation, coordination, and collaboration in assisting local prevention and youth development activities.
- Increasing the visibility and effectiveness of existing state prevention and youth development resources to help communities organize against substance abuse and promote resources for youth.

County designated Intoxicated Driver Program (IDP) assessment agencies are responsible for assessing Wisconsin drivers convicted of operating while intoxicated (OWI). Assessors use a Wisconsin-specific IDP assessment (Wisconsin Assessment of the Intoxicated Driver - WAID) to determine whether drivers need education, treatment or both. Approximately 30,000 adjudicated intoxicated drivers received assessments of their alcohol and other drug use under this program. Of these, one-half receive substance abuse treatment services from community programs. Data reported by the DOT show that 76 percent of convicted drivers complete their treatment-oriented driver safety plans and 86 percent do not re-offend during the five years following their arrest. The IDP is one of the Department's most successful programs of intervention and treatment for substance use disorders.

The Statewide Urban/Rural Women's Alcohol and Other Drug Abuse (AODA) Treatment Project provided grants for eight community and evidence-based women and family-centered treatment programs. The project serves adult women in need of AODA treatment who are also involved in at least one other formal service system. Priority of treatment services is given to pregnant women. Annually, 435 women and 223 children are served.

Three criminal justice diversion projects called the Treatment Alternative Program are funded by the Wisconsin DHS. The program is based upon the successful Accountability for Safer Communities model. The program operates in three urban counties and serves several hundred offenders each year. The Wisconsin DHS awarded grants to four county treatment agencies in northwest Wisconsin, Barron, Burnett, Polk and St. Croix, where local officials have identified significant need for methamphetamine treatment using the Matrix Model. The agencies implemented the evidence-based Matrix Model and in concert with criminal justice agencies, have reduced the methamphetamine problem in the area.

The My Baby & Me program is a fetal alcohol spectrum disorders (FASD) prevention initiative that is a collaborative, system-level effort to improve the ability of prenatal care coordination (PNCC) providers to address alcohol use by pregnant women. My Baby & Me is a partnership with the Wisconsin Women's Health Foundation (WWHF) and local maternal and child health care providers. My Baby & Me provides education, training, contingency management, and prevention strategies for PNCC providers, local agencies, and pregnant women. Approximately 40 pregnant women receive services each year reducing the adverse effects of alcohol and drug use on newborns.

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach addressing Wisconsin residents' use of alcohol and drugs through primary health care. The Wisconsin Initiative to Promote Healthy Lifestyles at the University of Wisconsin is implementing SBIRT services in selected health care clinics across the state. The program administers over 100,000 brief screens, conducts over 20,000 brief interventions, and makes hundreds of referrals to treatment each year.

The STAR-QI program promotes implementation of Plan-Do-Study-Act quality improvement (QI) projects to improve access to and retention in substance abuse treatment. DHS is working with the University of Wisconsin and 40 Wisconsin treatment centers to increase admissions, reduce appointment no-shows, reduce waiting times, and increase successful treatment completion. Since the program's inception, waiting times among participating STAR-QI agencies have been reduced from an average of 25 days to 11 days. Higher than average treatment completion rates have also been achieved – 10 percentage points above the state average and 18 percentage points above the national average.

The Alliance for Recovery Advocates **(**AFRA) is a statewide, consumer-driven, grassroots advocacy and support organization. AFRA includes people in the recovery community and allies of people in long term recovery. The program aims to build and mobilize strong grassroots recovery organizations across the state. AFRA has done work to accomplish the following:

- Create a statewide advocacy and advisory board to bring together men and women group members of diverse backgrounds, family members, supporters, and allies.
- Create a self-sustaining, statewide consumer driven organization.
- Establish and maintain a strong affiliation with the National Faces & Voices of Recovery organization.
- Carry a strong message of hope to all affected by addiction that recovery is real.
- Ensure that AFRA has a presence and coordinates recovery activities in both urban and rural areas of the state.
- Organize and coordinate support and resources for the September Recovery Month activities occurring throughout the state including Annual Rallies for Recovery.

In partnership with AFRA, Wisconsin has begun training individuals to become Recovery Coaches. Recovery Coaches are specially trained, non-clinical peers, certified to serve as a mentor and guide for others living with chemical addiction and/or dual disorders. The Recovery Coach empowers an individual in their personal journey towards recovery offering hope, while providing advocacy, guidance, motivation and knowledge.

Substance Abuse Prevention Services

Community Aids
Funding provided from the SAPT block grant is distributed to county governmental entities through community aids as a categorical formula allocation. As in past years, counties are required to spend these funds on eligible substance abuse services, including 20% on primary prevention services. Recipients of these funds are also required to identify services within Center for Substance Abuse Prevention's (CSAP) six-prevention strategy areas. Funds support prevention services and activities to reduce youth substance abuse among residents in each Wisconsin county and tribe. Services are delivered either directly through one of the states' county administered human service agencies or via a sub-contract with a local provider.

Programs established with these funds must comply with DHS 75, Community Substance Abuse Service Standards. Counties are required to comply with applicable SAPT Block Grant guidelines. Funds will be distributed via State/County contracts on a calendar year contract period.

American Indian Program
The DHS, through its consolidated family service approach to contracting, continues to combine funds from four categorical programs into a single family-based program. SAPTBG and state revenues will be provided to 11 Wisconsin Native American Tribes for substance abuse prevention or behavioral health promotion services through the consolidated Family Services Program (FSP).

Wisconsin Clearinghouse for Prevention Resources (WCH)
WCH continued to support the five Alliance for Wisconsin Youth Regional Prevention Centers by coordinating statewide training and technical assistance services. The Wisconsin Clearinghouse is also the lead agency in developing and coordinating the Wisconsin Annual Statewide Prevention Conference. The 2013 Prevention Conference will be held September 11-13. The Wisconsin Clearinghouse also serves as the lead agency in coordinating the Parents Who Host Lose the Most campaign, the Prevention Speaks project, and the Transform Wisconsin Fund.

HIV Prevention Program
SAPT block grant funds continued to support HIV prevention education services targeted towards substance abusers and their sexual and/or needle sharing partners living in the Milwaukee, Wisconsin area. Service providers were prohibited from using funds for the purchase of inpatient hospital services,

syringes, needles or condoms. The Department contracted for these services through the Wisconsin Division of Public Health's HIV Prevention Program.

Brighter Futures Initiative (BFI)
This initiative merged ten categorically funded youth prevention programs and combined funds, staff, and resources towards a new youth development effort. Funding used to support this initiative is derived from several state and federal sources (i.e., Substance Abuse Block Grant, Wisconsin General Purpose Revenue, and Temporary Assistance for Needy Families). Local county BFI grantees are required to pool resources, leverage additional county administered dollars, and meet community driven outcomes. The overall goal of this program assists youth and families to be safe, healthy, self-sufficient members of their community.

Parents Who Host Lose the Most Campaign
The "Parents Who Host Lose the Most: Don't Be a Party to Teenage Drinking" campaign in Wisconsin is a unique collaboration of seven state agencies and state programs, working together with local coalitions, to increase parental awareness of the legal and health consequences of hosting underage drinking parties. The program was created by the Ohio Drug Free Action Alliance in 2001, granted "Promising Practice" status by the Federal Substance Abuse and Mental Health Services Administration in 2002, and has since been used in 49 states to reduce both commercial and noncommercial access to alcohol by teens.

The program's goal is to educate parents and other adults about the health, safety, and legal risks of serving alcohol at teen parties. The campaign in Wisconsin has increased awareness of compliance with Wisconsin underage drinking laws with the goal of reducing youth access to alcohol.

Alliance for Wisconsin Youth Regional Prevention Centers
The Department of Health Services provides funds to each of Wisconsin's five Alliance for Wisconsin Youth Regional Prevention Centers. These funds are used to build capacity for the delivery of effective substance abuse prevention strategies among Wisconsin's 120 Alliance for Wisconsin Youth local community coalitions. The Alliance for Wisconsin Youth Regional Prevention Centers also serve as a conduit between the Department and local coalitions to identify local issues, service gaps and needs and provide information to coalitions regarding funding, training, state policy change, and local strategy development.

Mental Health and Substance Abuse Services for Adults

Within Wisconsin there has been a continuum of services that have developed to meet the needs of persons with behavioral health and substance abuse disorders. Originally there was a large divide between mental health and substance abuse treatment programs. With the evolving service system, various programs are not only expected to treat persons with co-occurring disorders but are progressively more skilled at doing so. One of the original programs utilized in Wisconsin is the outpatient mental health program. This program is designed as a Medicaid reimbursed clinic where a person can see a psychotherapist, psychiatrist, or nurse prescriber. The outpatient rule was revised (2009) to allow for more flexibly rendered services and most recently licensed psychotherapists can now practice independently.

Comprehensive Community Services (CCS) and Community Support Programs (CSP)
CCS and CSP attempt to eliminate "silos" of services. CCS utilizes an advisory committee which consists of members from county human services departments involved, economic support agencies involved in CCS eligibility, administration and provider certification, child welfare, providers and consumers. As committee members, the providers and interested parties are able to provide feedback to the CCS program regarding policies, practices and procedures that are recovery-oriented and person-

centered. Services must be psychosocial rehabilitative in nature, meaning that they must result in greater independence or minimizing the effects of the illness. The services should reflect positive results on quality indicators, participation on recovery teams, compliance with supervision and training to keep the staff skills current, and culturally competent services.

CSPs provide coordinated care and treatment thru a single agency. This program provides a range of treatment, rehabilitation, and support services in the community through an identified treatment program and staff ensuring ongoing therapeutic involvement and individualized treatment for persons with severe and persistent mental illnesses. Additionally, CSPs work collaboratively with other community partners and support consumers in utilizing outside resources such as housing programs, Medicaid, Social Security, and self-help groups. The program uses the Assertive Community Treatment (ACT) model as foundation, which was developed at the Mendota Mental Health Institute in Wisconsin. The CSP has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, rehabilitation, crisis, and supportive services to persons who have a serious and persistent mental illness that affects both their ability to live independently in the community and to function in major life roles.

In FFY 2011, the State provided training and offered incentives and encouragement for the 78 CSPs to incorporate SAMHSAs Evidence Based Practices (EBP) into their clinical practices. The State's annual CSP survey tracks the adoption and use of EBPs. Moreover, Wisconsin's CSP regulations require all CSPs to "develop and implement a training plan for all staff on current principles and methods of treatment, rehabilitation and support services for [seriously and persistently] mentally ill persons." These efforts promote the use of EBPs and a continuous quality improvement process in Wisconsin. The State has made available, and will continue to make available, training for all CSPs in the EBPs most applicable to the CSP client population, including Assertive Community Treatment, Supported Employment, and Integrated Dual Disorders Treatment. To date, many CSPs have received this training and the majority of Wisconsin counties and regions have certified CSP programs.

Community Recovery Services (CRS)
Since 2010 Wisconsin has also employed the use of Community Recovery Services (CRS). CRS provides psychosocial rehabilitation services for adults and children with serious and persistent mental illness living in a community setting (i.e., home, adult family home, a community based residential facility, or residential care apartment.) The services provided to Medicaid members through the CRS Medicaid benefit are done so via contracts between certified counties/tribes and local service providers. A county or tribe may provide one or more of the services directly. CRS eligibility requires that the consumer have a diagnosis of mood disorder, schizophrenia, or other psychotic disorder in combination with a functional need for community assistance. Eligibility for the CRS State plan HCBS benefit is determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5).

Wisconsin's CRS benefit expects recovery-oriented, outcome-based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. Three services are provided through the CRS initiative:

1) Community Living Supportive Services (CLSS) covering services necessary to allow individuals to live with maximum independence in community integrated housing including skill training, cuing and/or supervision as identified by the person-centered assessment.
2) Supported Employment Services includes services necessary to assist individuals to obtain and maintain competitive employment using Individual Placement and Support (IPS) model recognized by SAMHSA as an evidence-based practice.
3) Peer Support Services utilizing individuals trained and certified as Peer Specialists to serve as advocates, provide information and peer support for consumers in outpatient and other community

settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process.

During 2012, 23 counties throughout Wisconsin were certified by DMHSAS to provide CRS. Of those, 18 counties were actively participating and submitting CRS service plan packets. A total of 210 participants were receiving services, an over 140% increase in participants from 2010. Out of the 210 participants, 178 were receiving daily Community Living Supportive Services, 27 were receiving periodic Community Living Support Services, 57 were receiving Peer Support Services, and 37 were receiving Supported Employment Services.

Services for Youth

Coordinated Service Team Initiative
There are growing county and tribal initiatives in Wisconsin to assist children and youth with behavioral health conditions. The Coordinated Services Team (CST) initiative is designed to develop coordinated systems of care for children and adolescents with Severe Emotional Disorder (SED), and their families, who require support from multiple community-based agencies. Under the CST plan a county or tribe is to establish a strength-based system of care that supports children and adolescents along with their families, mental health, juvenile justice, and/or child welfare services. Through these efforts an overall systems change is possible, which can establish a collaborative system of care which provides counties and tribes the capacity to meet the needs of youth and their families. The 2009 Wisconsin Act 334 allowed for the expansion of CST services to youth who were not diagnosed with an SED, but who were involved in more than one system of care and had a risk of going into an out of home placement. More recently, Governor Scott Walker announced a budget proposal and the legislature approved an expansion of CST statewide by the end of 2016.

Healthy Transitions Initiative
Another promising approach for youth in Wisconsin is the Healthy Transitions Initiative (HTI). The project supports older youth and young adults with severe emotional and behavioral disorders who need additional time and support to make a positive transition into adult roles as caring, competent and contributing members of their communities. HTI is designed to be strengths based, recovery oriented, age and culturally appropriate. Statewide, the initiative endeavors to make what is a traditionally cumbersome transition between youth and adult mental health systems seamless. One example of this initiative is the O'YEAH project, which provides wraparound services in Milwaukee helping youth make the transition to adulthood.

Program for Assertive Community Treatment
Another initiative showing very good promise for mitigating disability of youth whose trajectory is into the adult mental health system is the youth initiative of the Program for Assertive Community Treatment (PACT). The PACT admits youth before their 18th birthday in an effort to help them achieve mental health stability and to complete school and obtain employment. Results of this effort in the first number of years of operation are very encouraging and may serve as another PACT-inspired national model.

Children's Long-Term Support Waivers
Children's Long-Term Support (CLTS) waivers, managed by the Division of Long-Term Care, address the needs of children age 17 and under who meet different federal target groups, including physical disabilities, SED and developmental disabilities. For children with SED, the eligibility age extends out to age 21. Aside from age and disability, the CLTS wavier requires that the child live at home but require services at the level of care typical to an intermediate care facility for the mentally retarded (ICF-MR), nursing home, or psychiatric hospital. Moreover, the cost of care under the waiver program must not exceed that which it would cost to provide services in such an institution. Each of the approved waivers

provides community supports and services to children with significant disabilities and long-term support needs. The waivers offer services such as service coordination, supportive home care, respite care, specialized medical and therapeutic supplies, and other supports for children. The waivers also include intensive in-home autism treatment services. The community supports available through the waiver are cost-effective and assure that children are at home with their families.

As of December 31, 2009, there were 848 children waiting for intensive in-home autism services through the CLTS Waivers. In 2009, numbers of children served who had the following disabilities include: developmental disabilities, 2,775; physical disabilities, 297; and severe emotional disturbances, 1,137. There are 1,377 children that transitioned from the intensive in-home autism services to the on-going services in the CLTS Waivers. There are 1,210 children receiving services through locally matched waivers, 50 children in pilot slots, 95 children in crisis slots and 629 children in special state-funded slots. As of October 31, 2010 there are 4956 children participating in the CLTS Waivers. The cost estimated to keep serving current children on waiver is $25.5 million in 2011 and $26.2 million in 2012. The autism waiver was expected to remain at $41.7 million per year in 2011-2013 biennium.

Services for Older Adults

Wisconsin has developed various infrastructures to provide long-term care to persons who have a disability or infirmities of aging. Presently, the long-term care arena in which to help frail elderly and physically or developmentally disabled with community living skills is largely conducted through the State's Family Care program. Family Care provides long-term care services to Medicaid-eligible adults in a cost contained managed care environment. Family Care does not pay for inpatient hospital or physician services as those are provided through Medicaid card services. The Family Care benefit includes community mental health services including outpatient mental health and Community Support Program services. The Family Care Partnership and Program of All-Inclusive Care for Elders (PACE) provide all Medicaid services as well as all Medicare services for those who are Medicare eligible.

Another program in Wisconsin associated with Family Care is the *Include, Respect, I Self-Direct* (IRIS) program. IRIS is a self-directed home and community-based waiver program with a monthly allotment where the participant can use public funds and natural supports to craft their own support and service network. These programs are connected to Aging and Disability Resource Centers (ADRC), which serve as the entry point for a person who may need supportive community services. Thirty-five ADRCs serving 59 counties are located across the state in counties that provide Family Care. Data show that over half of those enrolled in Family Care also carry a mental health diagnosis.

Services for Special Populations

Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) Populations
LGBTQ people in Wisconsin face obstacles in receiving health care and often experience the barriers of stigma and discrimination. The DMHSAS has been working with the Department of Public Instruction (DPI) and other DHS staff in developing the DPI model bullying policy for schools and communities. Creating safe and supportive school environments for all youth and young adults who identify as lesbian, gay, bisexual and transgender is essential for ensuring educational success.

Data from the Wisconsin Youth Risk Behavior Survey 2010 (YRBS) indicates that nearly 4 percent of all high school students reported that they did not attend school on one or more days in the past 30 days because they felt unsafe at or on their way to or from school. This percentage increases to 15 percent among students reporting same sex behavior. Students reporting same sex behavior were also more likely to report depression, and consider or attempt suicide.

DMHSAS has worked in partnership with the Division of Public Health to develop the state public health plan, Healthiest Wisconsin 2020. The mental health focus area in the state public health plan includes metrics for suicide prevention; promotes access to services for LGBTQ youth; and includes an avenue for outreach and increased awareness of gender-based discrimination faced by individuals identifying as LGBTQ especially adolescents/young adults who may also have a mental health and/or substance use disorder. DMHSAS continues to identify supportive resources to address issues.

Youth Who Need Substance Use Disorder Services
Wisconsin provides nine county or state Juvenile Justice Alcohol and Other Drug Abuse Grants totaling $1,340,000 through funding from the Substance Abuse Prevention and Treatment Block Grant. This allocation provides services for intervention, prevention and referral to treatment for youth. In particular, one contract with the Department of Justice provides $281,600 to Milwaukee County to provide AODA services to youth. All funds are from the Substance Abuse Prevention and Treatment Block grant.

Individuals Released from Correctional Facilities
To reduce the number of barriers facing inmates as they transition to the community Wisconsin implemented the Opening Avenues to Reentry Success initiative (OARS). This multi-departmental initiative between the Wisconsin Department of Corrections (DOC) and Department of Health Services (DHS) was first introduced to in the state legislature in 2005, and received funding in 2010. Additional collaborative partners in the OARS program are the Council of State Governments, NAMI, correctional institutions, and Disability Rights of Wisconsin among others. OARS serves as a transitional program to bridge the gap between institutions and the community and supports the recovery and self sufficiency of offenders with mental health needs.

OARS provides several services including assistance in finding and maintaining housing, obtaining mental health services, education, employment, transportation, budgeting, and structured community activities. This is all done through the coordinated support and guidance of an OARS team of specialists, treatment providers, corrections, social workers, and family members, with a goal of developing a plan which will lead to success. The OARS initiative utilizes several evidence based practices such as medication compliance, dual diagnosis treatment, person centered and strengths based treatment planning, peer specialists, and a hybrid of other models such as PACT, ACT, and Forensic Intensive Case Management (FICM).

An offender is typically enrolled in the program for between six months and two years. A person completes the OARS program when the offender is maintaining stable housing independently, living without reliance on drugs or alcohol, is actively receiving local treatment, is financially independent, and making healthy decisions which support their recovery and mental health stability.

Intravenous (IV) Drug Users
DMHSAS provides funds that are used to implement innovative evidence based practices for the prevention and treatment of IV drug users (IVDU). The priority population has been identified as pregnant women who seek or are referred for and would benefit from Block Grant funded treatment services. A total of $2,000,000 is available for IVDU through the Substance Abuse Block Grant. The monies are divided into two categories: prevention and treatment. Areas of the state that have a high prevalence of Hepatitis C or HIV or a high prevalence of factors that would lead to Hepatitis C or HIV are given priority.

It is important to note that programs must exhaust other governmental and private resources (e.g., Medicaid, Badger Care, health insurance, etc.), and collaborating agencies are required to utilize existing resources to pay for treatment and other services before using funds provided by this grant.
Services under this program have three primary goals:

1. Prevent or reduce the complications associated with IV Drug Use.
2. Improve access to treatment for persons who use IV Drugs.
3. Provide outreach, prevention and treatment for IV drug abusers.

Injection drug users (IDUs) are also at risk for Hepatitis B virus (HBV) and Hepatitis C virus (HCV) infection through the sharing of needles and drug-preparation equipment.

Prevention and reduction of complications associated with IV Drug are essential in stopping the increase of HIV, Hepatitis C and other transmittable diseases. The development of prevention programming in counties where there is a high prevalence of IV Drug users is necessary due to the high correlation between IV drug use and Hepatitis C and HIV.

Access to services, prompt and adequate care and providers who are culturally competent are essential components for persons needing assistance. Programs must consider the gender, culture and environmental background of the person being served in order to render the most appropriate and effective services. Outreach services extend beyond usual agency activities to engage individuals who have, or are at risk of developing, a substance use or related health problem. Outreach focuses on reaching those who are hard to reach or hidden and not in contact with other services. Outreach activities may also be designed to reach people already in contact with services but who need accessible substance abuse treatment services. The development of outreach services are based on a careful assessment of the characteristics, life circumstances, and needs of the specific group who will receive the services. In some cultures, men and women live more segregated lives and this is taken into account in planning Wisconsin's outreach services. In some cases, such as homeless women, safety may be the primary concern.

Peer outreach will be used to reach persons who are not in contact with professional services or who live in places with strong resistance to substance use and treatment. Peer outreach workers will provide users with information on how to reduce risk behaviors, will teach by example, and will link those who use substances with treatment and other health and social services.

Individuals with HIV/AIDS
In 2011, 285 new cases of HIV infection were reported in Wisconsin. Over the past decade rates of HIV infection have remained stable, however cases among injection drug users (IDUs) have declined in Wisconsin (-25%) from 2002 to 2011, accounting for 8% of cases in 2011. The majority of IDU cases were White male (64%). Men who have sex with men (MSM) accounted for 72% of new cases reported in 2011, including 3% of cases among MSM who were also injection drug users. Cases of HIV infection have increased among MSM by 29% from 2002 to 2011. A 218% increase in young Black MSM ages 15-29 has occurred in addition to a 64% increase among young White and a 21% increase among young Hispanic MSM (Wisconsin HIV/AIDS Strategy, 2012).

The Wisconsin AIDS/HIV Program assumes public health responsibilities in Wisconsin for several programs and activities. These include a counseling, testing, and referral program, HIV partner services, and prevention education and risk reduction. In 2012 Wisconsin HIV/AIDS Strategy was released for 2012-2015. Part of this strategy is encouraging improved mental health and substance abuse screenings, organizing trainings for providers, and increasing funding for mental health and substance abuse care (Wisconsin HIV/AIDS Strategy, 2012).

A medical Health Home for the HIV/AIDS population has been approved by the Centers for Medicare and Medical Services early in 2013. This medical home will include Screening, Brief Intervention, and Referral to Treatment (SBIRT) for the enrolled population. These services will be provided along with other primary care and behavioral health care coordination.

Women with Substance Abuse Disorders
In 2012, the DMHSAS made $2,429,631 per year available to fund programs of no more than $500,000 for a single agency and $750,000 for a consortium or regional partnership. This grant is designed to address the multiple needs of women and their families to access family-centered services for their substance use disorders. These services are gender, culturally and linguistically relevant and focus on the empowerment of women to develop the necessary skills for long-term sobriety, improvement of parenting skills, relationship building, and to encourage education and job skills that promote family self-sufficiency. These services also include, where appropriate, mental health, trauma responsive approaches, therapeutic childcare, transportation and community, natural and recovery supports and/or other services that are necessary to provide wraparound care to women and their families.

Since the project's inception, services have expanded from 3 underserved counties to 14 underserved areas throughout the state. Currently the project provides service access to women of the Ho Chunk Nations with located in Sauk, Lacrosse, and Shawano Counties; Women in Urban and Rural communities may access programs located in Brown, Forest, Vilas, Oneida, Dane, Eau Claire, Dunn and Chippewa and Walworth counties with two women's programs located in Milwaukee County.

Family-centered treatment offers a solution to an intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve family functioning, child health and safety. This grant provides an opportunity to target women, as well as achieve and identify improved outcomes for evaluation. For women with children this grant provides therapeutic childcare services as necessary for treatment.

These services are targeted at women and their families and must be in need of services for substance use disorders and must have involvement with at least one other system, (e.g., correctional, child welfare, Wisconsin Works (W-2) economic support program, or require services to address homelessness, mental health, deaf and hard of hearing, blind and visually impaired, developmental disabilities, physical disabilities, or elderly services, etc.) Providers must identify the multi-system/services target groups involved and include what percent of these persons are uninsured. Providers must also interface with the other systems and service needs. In addition to providing services to this target population, priority treatment services must be provided to pregnant women per s.51.42 (3) (ar) 4m, Wis. Stat., 51.46, Wis. Stat., and DHS 75.03 (3) (g).

Programs must exhaust other governmental and private resources (e.g., Medicaid, Badger Care, private health insurance, etc.) and collaborating agencies are required to utilize existing resources to pay for treatment and other services before using funds provided by this grant program.

Rural Populations
Rural areas of Wisconsin mirror national patterns of shortages of mental health professions. This lack of mental health professionals, particularly for child and adolescent specialty, has resulted in frequent difficulty finding a psychiatrist for many residents.

The counties with the greatest overall need for any mental health professionals were Menominee, Crawford, Richland, Sauk, Adams, Marquette, Buffalo, Clark, Taylor, Price, Iron, Sawyer, Washburn, and Burnett - all mostly rural counties. All of these counties had rates of unmet need for mental health professionals that put them in the top quartile nationally for unmet need. Most other counties with similarly high levels of unmet need are found in the Great Plains, Rocky Mountains, or Alaska. Wisconsin counties in the lowest quartile nationally were primarily in the southeast area extending from Kenosha to Dane to Brown County.

All but four counties in Wisconsin have some level of psychiatrist shortages. Eight primarily rural counties have shortages of less than 1.0 FTE. Also noteworthy for prioritizing state psychiatrist needs is that 16 counties reported 0 psychiatrist FTEs providing on-site outpatient care.

To increase capacity, in particular in rural areas, Wisconsin continues to support several efforts. One key support is Wisconsin's 72 Community Support Programs (CSP's). However, due to limited capacity many consumers are placed on a waitlist prior to receiving services. The Wisconsin DHS allocates $1 million dollars annually to CSP's to help relieve these waitlists, although the funding is not enough to eliminate them. While some of the consumers placed on the waitlists received other services while they waited, the waitlist totals are indicative of the size of the gap in capacity for CSP's specifically. Twenty (28%) of the 72 CSPs reported the use of waiting lists in 2011 for participants they could not actively serve. There were 422 participants on these waitlists at some time during 2011, an increase of 100 people over 2010. Programs reported that the average time on their CSP waitlist for consumers was 6 months. Inadequate workforce capacity can sometimes be due to a geographical mismatch between available workers and consumers in need.

The use of TeleHealth in Wisconsin since 2007 has been increasing to help address the need for an array of MH/SA services. Psychiatry services in particular are lacking in many rural areas, but may be in surplus in some urban areas such as Dane County. There were 113 TeleHealth certifications in Wisconsin in 2012 for an array of MH/AODA services. TeleHealth is used approximately twice as much for mental health services compared to substance abuse services. Although there's room for expansion among all services, TeleHealth seems to be currently used more often for regular outpatient services and less for emergency/crisis services and psychosocial rehabilitation programs (CCS and CSP). Increased use of TeleHealth in CSP's could potentially be part of the solution to relieving the waitlist issue described above.

The use of peer specialists is another key initiative Wisconsin is utilizing to increase capacity. Although the initiative in Wisconsin is still relatively young, the number of peer specialists being trained to join the mental health workforce has been steadily increasing through efforts by the Department of Health Services. Peer specialists not only increase the capacity of an agencies work force, they can also improve the quality and effectiveness of treatment by establishing a collaborative, trusting relationship between the provider agency and the consumer. Work needs to be done to better connect certified peer specialists to mental health programs, educate prospective mental health agencies as to the value of peer specialists, and distribute peer specialists to cover a larger portion of the state. However, a 2011 survey found that 97 of 114 (85%) certified peer specialists were employed.

Services to Individuals Who are Homeless

In Wisconsin, the goal is to affirm the right of individuals with serious and persistent mental illness and people with serious substance abuse disorder to have safe, decent, affordable housing and choice in selecting a residence in their community. Comfortable and suitable housing is a cornerstone for virtually anyone to be self-sufficient and is a key element of SAMHSA's vision of home in a high quality health care system characterized by a self-directed and satisfying life in the community. Without a stable place to live, and a support system to help address underlying issues, persons with mental illness and substance use disorders often bounce from one emergency system to another. Studies show that it is more cost effective to house someone in stable, supportive housing than to relegate them to homeless, mired in the revolving door of high cost crisis care and emergency housing.

Through the Division of Housing in the Department of Administration (DOA)—through Projects to Assist in the Transition from Homelessness (PATH), and programs such as HOME Tenant Based Rental Assistance (TBRA), HUD-funded Emergency Solutions Grant (HEARTH 24 CFR part 91 and 576) and

state-funded shelter, transitional living, and homelessness prevention grants—Wisconsin provides a range of services to those who are homeless or are at risk of homelessness. Additionally, Wisconsin's initiatives in SSI/SSDI Outreach, Access and Recovery (SOAR) have assisted many homeless and disenfranchised individuals obtain urgently needed disability and insurance benefits with which to support a life off the street. Having related medical insurance greatly improves access to medical and behavioral health treatment.

Within DOA, one critically important Substance Abuse and Mental Health Services program is the Projects to Assist in the Transition from Homelessness (PATH). The central objective of PATH is outreach to locate and engage people experiencing homelessness who have a mental illness or co-occurring disorder and to facilitate enrollment in PATH services. Additionally, the United States Department of Housing and Urban Development (HUD) supported housing initiatives exist in both urban and rural communities across the state, funding transitional and permanent housing programs. HUD funds several levels of supportive housing including Safe Havens, Transitional Housing, and Shelter-Plus-Care. Although no new Safe Haven projects are being funded through HUD, existing programs provide a soft entry refuge for people who are unable or unwilling to immediately engage in supportive services.

Deaf, Deaf-Blind, Hard-of-Hearing

Many challenges exist for persons who have hearing loss including barriers to treatment such as cultural competency and linguistic appropriateness of services. Wisconsin is taking a deliberate approach toward this diverse and traditionally under-represented and under-served population. Through an inter-agency agreement between the DHS, DMHSAS, and the Office of Deaf and Hard of Hearing (ODHH) a Steering Committee was convened in latter 2010 to develop and vet a Strategic Plan for advancing understanding, care and support for deaf, hard of hearing and deaf-blind individuals in Wisconsin. While the Office for the Deaf and Hard of Hearing with support from the Division of Enterprise Services provides key oversight, this is a collaborative partnership with the members of the Steering Committee included several different agencies and persons both hard-of-hearing and deaf, as well as staff from the BPTR. A quarterly newsletter is being published and circulated on the Internet to keep stakeholders apprised and involved.

The Strategic Plan was founded on seven critical facts:

1. Many people in the deaf, deaf-blind and hard of hearing community do not receive mental health and/ or substance abuse services that meet his or her needs. The term "services" includes prevention, active treatment, supported transition and after-care.
2. People who are deaf, deaf-blind and hard of hearing and their families often do not have an understanding of mental health, mental illness and AODA including co-occurring disorders/problems and the related impact with physical health.
3. Society lacks a meaningful understanding and sensitivity about the experiences and needs of people who are deaf, deaf-blind or hard of hearing.
4. People working in mental health/substance abuse and related systems often do not meaningfully understand the experiences and culture of deafness.
5. There is a lack of thorough, accurate epidemiological data at the state and federal levels regarding mental health and AODA needs and treatments by persons who are deaf, deaf-blind or hard of hearing.
6. Sustainable resources and funding are needed to create the capacity to implement this plan and achieve the vision.
7. It will be neither quick nor easy to create change so that people of all ages who are deaf, deaf-blind or hard of hearing received mental health and substance abuse AODA services that meet the unique needs of each individual.

Out of the Steering Committee's analysis, the following goal areas were established:

1. Increasing understanding among individuals who are deaf, deaf-blind or hard of hearing and their families/social supports about mental health, AODA, and recovery.
2. Increasing understanding within the mental health and AODA systems about how to provide effective services for individuals who are deaf, deaf-blind, or hard of hearing.
3. Expanding system capability and sustainable resources and funding for improved access to communication, technology, and peer/family supports.
4. Developing long-term collaborative partnerships between people who are deaf, deaf-blind and hard of hearing, their families, and representatives of mental health and AODA systems and relevant others.
5. Collecting meaningful data on prevalence, gaps/needs of services to address the mental health, AODA, and health care needs of individuals who are deaf, deaf-blind, and hard of hearing and their families.

These goals to improve mental health and substance abuse services to the population of those with hearing loss were then reviewed with a group of about 80 invited stakeholders at a highly successful day-long summit in March 2012. From the summit, plans were developed and prioritized for implementation. Out of the summit were convened several workgroups to advance the goals of the Strategic Plan. Each workgroup is implementing a work plan. Workgroups engage in cross-workgroup collaboration and call in outside expertise for consultation. The initial workgroups are as follows:

- Information—to develop information resources for members of the deaf/deaf-blind/hard-of-hearing community as well as resources for the behavioral health community. One outcome is the development of a "toolkit" or other educational vehicle for mental health and substance abuse providers to better understand the needs of people who are deaf, hard of hearing and deaf-blind
- Licensure & TeleHealth—to develop paths for training, supervision and licensure for competent behavioral health providers (including those who are deaf/deaf-blind/and hard-of hearing), retaining providers in the state, and promoting TeleHealth resources to afford access to services and supervision of providers. One outcome measure is the reduction of roadblocks to mental health and substance abuse provider licensing for qualified people who are deaf. Another is the creation of a TeleHealth project.
- Board & Linkages—to develop more involvement and presence of this minority community on key boards, committees, and work groups. Outcomes are expected to include increased numbers of deaf, hard of hearing and deaf-blind representatives on key mental health boards, committees and councils with a minimum of 2-5 appointments by the end of FFY-13
- Technology—to explore technological resources that can be brought to bear toward increasing awareness and availability of, as well as access to appropriate services.
- Funding & Resource Development—to link the subcommittee priorities to resources to support the development and maintenance of recognized initiatives on the part of the Steering Committee.

Strengths of the Wisconsin Mental Health and Substance Abuse Services System

Wisconsin over the years has served as a leader in many initiatives, modeling developments in the behavioral health infrastructure for other states. Pioneering efforts in community mental health in psychosocial rehabilitation were researched in Wisconsin through PACT (or Programs for Assertive Community Treatment). Around the same time, in the 1970s the National Alliance on Mental Illness (NAMI) was founded in Wisconsin. DMHSAS is working with NAMI-Wisconsin, the Wisconsin Alcohol and Drug Treatment Providers Association (WADTPA), AFRA, Wisconsin Family Ties (WFT), Mental Health America of Wisconsin (MHA), Disability Rights Wisconsin (DRW), Grassroots Empowerment Program, Inc. (GEP), Wisconsin United for Mental Health (WUMH) to continue development of Wisconsin's behavioral health infrastructure for adults and children. These groups are also working to counter stigma and discrimination in Wisconsin while conveying accurate and unbiased

information about mental illnesses, severe emotional disturbance, and substance abuse disorders in the interest of promoting recovery and the adoption of evidence-based practices.

Behavioral Health Regionalization Pilots
In September, 2009 the DHS issued the "Wisconsin Public Mental Health and Substance Abuse Infrastructure Study", which reviewed the current funding and delivery of public MH/SA services in Wisconsin and other states. The study also then identified models and pathways for system reform. From this study, a shared-services regionalization pilot grant was developed and awarded in summer 2012. The grant was awarded to two multi-county consortia that are piloting innovative three-year demonstration projects that use shared public services across organizations or in multi-county regional networks. The two regions selected were 1) Western Region Recovery and Wellness Consortium (WRRWC) and 2) Western Region Integrated Care (WRIC) Consortium. These consortia, both located in the western part of WI, encompass both urban and rural populations. Each consortia plans to carry out extensive needs assessments and involve multiple stakeholders in program redesign. The redesign seeks to increase "core benefit" access for consumers, as well as increase administrative efficiencies, including moving toward shared IT infrastructure in the regions.

Certified Peer Specialists and Recovery
Under the leadership of the BPTR and Access to Independence, Inc. an independent living center has developed a certification process for peer specialist services. Proof of required training and a state sponsored exam are the central components of the process. The independent living centers in the state serve as exam proctors; the University of Wisconsin-Milwaukee manages the tests and scores the results. DMHSAS also partners with the University of Wisconsin - Madison School, of Medicine and Public Health to provide Recovery technical assistance. DMHSAS continues to work with the Recovery Implementation Task Force (made up of a majority of consumers) to provide advice on a range of initiatives that promote recovery.

Partnerships with Non-Profit Organizations That Focus on Self-Directed Care
In Wisconsin a number of partners support efforts through training. For example, NAMI provides a number of courses such as Peer-to-Peer, Peer Support Group Facilitator Training, as well as Parents and Teachers as Allies and Family-to-Family. Person-centered planning has been implemented across a variety of sites in Wisconsin through DMHSAS leadership. Other supports of self-directed care include: NAMI-Wisconsin's Consumer Council, a Consumer Leadership Summit, the WFT's Children Come First Conference, and various recovery centers and drop in sites across the state.

Supporting Purpose for Consumers
Wisconsin's strengths within the realm of SAMHSA's vision of purpose in the community is the web of employment resources from Wisconsin's network of Job Centers in many communities, the provision of vocational rehabilitation services through the Department of Workforce Development (DWD), Division of Vocational Rehabilitation (DVR) and a variety of other efforts such as supported employment initiatives through a continuum of psychosocial rehabilitation programs. Employment agencies use Ticket to Work (TTW) vouchers to assist individuals in navigating a difficult employment environment. Many technical college and university campuses have special needs counselors or programs which can help persons with disabilities successfully complete training programs. A network of twelve Cooperative Educational Service Agencies (CESA) across the state supply supportive and educational services, employment assistance, job coaching, and a host of other services, each to their own respective region. Similarly, eight Independent Living Centers (ILCs) across the state are consumer-directed, non-profit organizations that provide four core services: (1) peer support; (2) information and referral; (3) independent living skills training; and (4) person and systems advocacy.

Use of Evidence Based Practice
Wisconsin has committed to increasing the use of evidence based practices (EBP) in delivering mental health and substance abuse services. This has been done to ensure services meet good clinical and safety standards, utilize best practices, and ensure clients receive best of fit satisfactory services which provide maximal benefit. Moreover, the use of EBPs and client satisfaction are on the list of priorities among stakeholders. National studies suggest that the vast majority (70%) of addiction treatment counselors would agree that it is good practice to use treatment approaches proven by research. However, only 40% may actually use EBPs. Barriers include lack of time or funds, lack of administrative support, insurance restrictions, and potential client resistance. What's equally important is collecting and using data on treatment effectiveness in order to "prove the practice." Ongoing planning in Wisconsin aims to reduce these barriers, and improve the collection and utilization of data to inform services provided.

Among current efforts to assess the use of evidence based practices is an annual DMHSAS survey of all CSPs across the state. The survey has asked program staff for information on their use of EBPs since 2007. The DMHSAS provided grant funding to select counties from 2006-2008 to implement EBPs for adults and has more recently funded training for Supported Employment. However, many counties and CSPs have independently chosen to implement EBPs.

Of the 72 CSPs reporting in 2011, Assertive Community Treatment (ACT) was used by 61% of programs (N=44). All other EBPs such as Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) were used by just over a third of programs with the exception of Family Psychoeducation. Eighty-two percent of CSPs used at least one EBP with their consumers.

Conditional Release Program
Wisconsin operates state forensic programs to serve persons who are to be assessed for competency to stand trial, who have been committed for treatment to competency, or were found by a court of law to be not guilty by reason of mental disease (NGI) or defect of a felony or misdemeanor. Individuals found NGI by a court may be placed directly into the community under Conditional Release or committed for institutional care. If committed for institutional care, the person may then petition for Conditional Release every six months. A Conditional Release requires community placement and mental health treatment with coordinated supervision by a contracted case manager and a probation and parole officer who has received training in mental health issues.

The Conditional Release Program has funded, coordinated and administered quality forensic mental health services to 431 clients during FY12, with an average daily population of 284 clients. The overall mission of the program is community safety by assisting clients to achieve their highest level of mental health and independent functioning has been met this year. The outcome indicators for mental health stability and highest levels of independent functioning include independent living situations and employment. Clients have been very successful, as evidence by the fact that 78% live in independent living situations and 39% are employed or going to school. The number of Conditional Release clients living independently of Community-Based Residential Facilities (CBRF) has increased 2% over last year.

The preliminary outcome measures of community safety are revocation rates and new crimes committed. This year the Conditional Release Program's client population reached a program high, with the most new program admissions, yet the rate of Conditional Release clients receiving a new criminal conviction dropped to .2%, the lowest in the last 8 years.

The Conditional Release program will continue supporting the development of skills such as Motivational Interviewing, Person Centered Planning, developing Trauma informed case managers and resources and identify the Stage of Change and engage clients in a process to go forward in the stages of change to

recovery. Along with these measures, many performance goals/expectation performance standards have been increased and performance expectations will again be measured for FY13.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Section II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

To identify unmet needs and gaps in Wisconsin's current behavioral health service system, Wisconsin's Division of Mental Health and Substance Abuse Services (DMHSAS) engaged in a comprehensive needs assessment process that lasted throughout 2012 (Appendix 1). Wisconsin's needs assessment process focused primarily on existing data, but went well beyond data and needs assessment analyses presented in previous State Mental Health and Substance Abuse Plans.

Description of the Wisconsin Needs Assessment Process
The needs assessment became an independent project preceding the development of the FY 2014-2015 Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant (BG) Plan. The needs assessment involved a comprehensive review of data and an extensive effort to gather input from consumers, advocates, the Wisconsin Council on Mental Health (WCMH), and the State Council on Alcohol and Other Drug Abuse (SCAODA). A combined committee of WCMH and SCAODA members was established to provide guidance and direction about issues to examine, to review the analyzed data, provide a preliminary ranking of priorities and assist with developing strategies and performance indicators. The combined committee and the DMHSAS met throughout 2012. Their design work for the needs assessment resulted in four broad categories of data and information to be collected and analyzed.

I. Population(s) Affected. This refers to the prevalence of disorders, conditions and associated problems for the entire population as well as for special populations such as the homeless, females, racial and ethnic groups, youth, older adults, veterans, rural populations and criminal justice offenders. The analysis answers the questions: 1) what are the problems, 2) what is the extent of the problem(s), and 3) what is the need for services, strategies, supports or treatment across different populations?

II. Access to Services, Strategies, Supports and Treatment. Are populations able to gain access to services, supports or treatment? Are prevention strategies in place in communities? Do people receive preventative, treatment, or support services when (timeliness) and where (geographically available) they need it? What are the barriers to receiving services? What proportion of the population are recipients of services, strategies, supports and treatment (treated prevalence or penetration rate)?

III. Availability and Capacity of Services and Strategies. What types of services and strategies are needed and what is the capacity of the system (including number of providers and workforce characteristics) to meet the needs? What is the capacity of the system to provide a culturally and linguistically appropriate mix of services to meet the needs of the populations affected? Are the resources in the system appropriately aligned and cost-effective (i.e., relative use of more intensive inpatient care compared to other community based care)?

IV. Quality, Outcomes and Impact (effectiveness) of Services, Strategies, Supports or Treatment. Do people receive appropriate preventative, treatment or supportive services? Are the services, strategies, supports or treatment of desired quality? Are the services or strategies safe, client-centered, efficient, equitable, evidence-based, effective or otherwise proven to work? What happened to the consumer and/or the system as a result of the interventions, strategies, services or supports? What is the impact? What is and is not achieved to ameliorate the condition, disorder or problem? Outcomes to be measured also include what consumers believe are important to them as well as those outcomes important for the overall system.

Collaboration with Other Agencies to Identify Overall Unmet Behavioral Health Need
The focus of the first two sections of the needs assessment report was to identify the prevalence of needs, the access to services (number of clients served), and the difference between the two which represents the unmet need in Wisconsin. While the DMHSAS collects data for the public county mental health and substance abuse service systems, it does not typically have access to data from other state agencies that provide or pay for behavioral health services. However, for the needs assessment, the DMHSAS worked with State mental health institutes, the State long-term care agency, the State corrections agency, and the State Medicaid agency in a coordinated effort to calculate an unduplicated count of behavioral health consumers served in a year. The effort also included data from commercial insurers who fund behavioral health services in the private sector. The count of clients served across these different sectors is designed to provide an assessment of unmet need that is more comprehensive than previous efforts.

Based on prevalence estimates, 1,037,297 people in Wisconsin are estimated to have any type of mental illness in 2011: 833,256 adults and 204,041 children. Based on the combination of data from the private sector and multiple state agencies in the public sector, 526,735 people in Wisconsin were estimated to have received some type of mental health treatment in 2011: 416,111 adults and 110,624 children. The difference is the estimated number of people with mental health needs who did not access treatment in Wisconsin, or the estimated "treatment gap". Estimates indicate that 49% (510,562) of people with any mental illness in Wisconsin in 2011 did not access treatment. Among adults, 50% (417,145) did not access treatment. Among children, 46% (93,417) did not access treatment.

A 2007 national estimate based on survey data from the National Survey on Drug Use and Health (NSDUH) found 55% of adults who experienced serious psychological distress (SPD) did not receive mental health services in the past year. A 2009 NSDUH estimate indicated a high proportion of adults with "any mental illness" (AMI) (62%) or "serious mental illness" (SMI) (40%) did not receive any mental health services. Based on these estimates, Wisconsin's mental health treatment gap is narrower than the national average.

In a review of the number of people who needed substance abuse treatment who received treatment, the 2010 National Survey of Substance Abuse Treatment Services – Wisconsin sample, found that there were 306 persons in treatment on any given day per 100,000 population or a total of 17,385 persons. The national average across states is 381 persons in treatment per 100,000 population indicating that Wisconsin's rate of treatment is 20% below the national average in this study.

The 2010 National Survey on Drug Use and Health-Wisconsin sample provides an estimate of the rate and number of persons needing but not receiving substance abuse treatment. According to the survey, 448,000 youth and adults needed treatment in Wisconsin that year but only 8% or 36,000 persons received treatment. For youth, the percentage receiving treatment is 3% or 1,100 persons. Since these data are considered low-end estimates, further analyses are needed (described below) to arrive at a more accurate annual treated prevalence.

An analysis of Wisconsin Human Services Reporting System (HSRS; County-authorized and subsidized treatment), standard Medicaid and private insurance data will provide the best picture of the treated prevalence in Wisconsin. The analysis is presented in the table that follows.

	HSRS	Medicaid	Overlap of clients between HSRS and Medicaid	Total Number of Persons Served with Public Support
Unduplicated Persons Receiving Substance Abuse Services, 2010	48,100	11,800	5% or 2,900 persons	57,000

It should be noted that substance abuse service data from private insurers is not included in the above table and as such the 57,000 persons served in a year is incomplete. Based upon survey data showing that about 46% of persons receiving services have private health insurance or self-pay, the grand total number of persons receiving treatment in Wisconsin in 2010 could approach 105,550. This 105,550 figure is corroborated by data obtained from the private sector. Data from private commercial insurers identified approximately 42,410 persons receiving substance abuse treatment. A revised estimate of treated prevalence would be very close at 99,410. The total number of persons receiving substance abuse services each year is estimated to be between 99,410 and 105,550. Using the upper end figure of 105,550 persons receiving treatment each year, Wisconsin's treated penetration rate would be estimated at 105,550/448,000 or 23%, or a 77% rate of unmet need.

Quantitative Data Sources for the Needs Assessment
In addition to the data collected from other state agencies described above, a variety of other primary and secondary data sources were used in the Wisconsin needs assessment. Some of these included the United States Census Bureau, National Survey on Drug Use and Health, Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System, CDC's Youth Risk Behavior Surveillance System, Wisconsin Mental Health Statistics Improvement Program (MHSIP) survey, Wisconsin County Public Treatment Form, and specific program system surveys for Wisconsin's major psychosocial rehabilitation programs.

In addition to survey data, state agency administrative databases were also used extensively. The following databases were used: Wisconsin Human Services Reporting System (public behavioral health data), Wisconsin Medicaid Claims database, Wisconsin Crime Information Bureau, Wisconsin Public Health Profiles, Wisconsin Mortality Records database, Wisconsin Traffic Crash database, and others. These sources are footnoted in the respective report and citation sections in the formal Needs Assessment report (Appendix 1).

Consumer and Advocate Input
Other sources of data for the needs assessment included stakeholder input. Input from consumers and consumer advocates was obtained through a survey asking about the most important unmet needs, populations and service improvements that should be addressed. In addition, the United We Stand Wisconsin Network of the Grassroots Empowerment Project (a state-wide organization controlled and directed by mental health consumers/survivors whose purpose is to help people labeled with a mental illness exercise power in their lives) conducted a listening session among consumers/survivors. Their most important needs are as follows in no particular order:

- Healthcare
- Prevent mental health hospitalizations
- More consumer-run support groups or centers
- More Peer Specialists

- Prevent or provide mental health services for persons who come in contact with the criminal justice system
- Address stigma and discrimination
- Protect or increase public funding for mental health services
- Affordable public or private health insurance

Tribal Nations Input
Wisconsin's eleven Tribal Nations provided input through the above-mentioned survey as well as listening sessions conducted during 2012. Their most important needs are:

- Shortage of mental health and substance abuse professionals, in-home services and services in general
- Community awareness, education and prevention of mental health and substance abuse conditions
- Protect or increase public funding for mental health and substance abuse services; Medicaid reimbursement for case management and traditional tribal healing methods and other funding-related issues
- Training for mental health and substance abuse professionals
- Transitional housing
- Integrated services for co-occurring mental health and substance use disorders
- Address issues of rising non-prescription misuse of opiates

Unmet Needs and Gaps
The needs assessment report presents a multitude of data-driven problems, issues, needs and gaps. Based on their experience and review of the needs assessment report, stakeholders were asked to submit a list of the needs and gaps in Wisconsin's behavioral health system. The final combined list included 26 needs and gaps.

To be equitable to both the mental health and substance abuse fields and to both the prevention and treatment approaches, it was decided to group the needs or issues into three categories, namely 1) substance abuse prevention and treatment needs, 2) mental health prevention and treatment needs, and 3) prevention and treatment needs common to both mental health and substance abuse.

Given current resources, not all needs and gaps can be addressed simultaneously and so the next step was to prioritize them. A tool based on a public health program priority rating model (see Appendix 1: Needs Assessment Report) was developed for stakeholders to objectively rate and rank the 26 needs and gaps. Stakeholders rated each need on the following characteristics: consumer functional impact, fiscal impact, volume of need, comparison to national benchmark, consumer priority, availability of knowledge and resources to address need, long-term trend direction, and federal priority. The ratings for each domain were summed in the calculation of the overall rating for an item. Overall item ratings were then averaged across all stakeholders. The table below presents the priorities in rank order. These rankings were utilized to inform the priorities, objectives, strategies and performance indicators selected and developed for the Wisconsin Behavioral Health Plan.

Wisconsin Ranked List of Needs

Priority Score	Item Category	Item Description
81.2	SA-2	Reduce substance use disorders for pregnant women and mothers with infants and young children.
79.9	MHSA-3	Increase children and youth who receive effective treatment and wrap-around services for mental health or substance use disorders. Youth have high rates of mental health and substance abuse needs.
79.6	MH-1	Increase psychiatrist availability including, but not limited to, child psychiatrists in northern Wisconsin.
77.7	MHSA-4	Increase persons coming in contact with the criminal justice system that receive effective services for mental health or substance use disorders. These persons have high prevalence rates.
77.4	MH-2	Reduce Wisconsin's suicide rate below the national average including but not limited to persons age 50-59, veterans and active service members.
77.0	SA-8	Reduce alcohol and other substance-impaired motor vehicle crashes, injuries and fatalities among persons age 16-34.
75.8	MHSA-11	Improve mental health and substance abuse service outcomes and quality of care by addressing the use of evidence-based practices and treatments, practice-based evidence, consumer satisfaction and involvement, professional training, data collection, outcomes measurement, quality improvement approach, etc.
75.0	SA-1	Increase the substance abuse treatment professional workforce statewide.
74.4	MH-4	Early identification of those who have experienced adverse childhood experiences such as abuse, divorced parents, or living with persons who have a mental health or substance use disorder coupled with proven interventions to build resilience.
74.3	MHSA-6	Address barriers to accessing mental health or substance abuse treatment including cost, motivation, transportation/distance, living in rural areas, and stigma in order to increase the number of persons receiving treatment.
73.9	SA-7	Reduce binge or heavy-occasion use of alcohol among persons age 18-34.
73.9	SA-6	Reduce use of alcohol among persons age 12-20.
73.3	SA-3	Reduce persons with addictions to prescription pain killers and heroin as well as overdoses and deaths among persons age 12 and older.
72.1	MHSA-1	Increase persons with any co-occurring mental health or substance abuse disorder who receive effective integrated treatment.
72.0	MHSA-8	Increase overall mental health and substance abuse workforce capacity and reduce waiting lists.
71.2	MHSA-9	Achieve mental health and substance abuse service appropriateness and equity by ensuring the appropriate mix of inpatient, detox, residential, intensive outpatient, outpatient, psychosocial rehabilitation services, crisis intervention, recovery support services, peer specialists, recovery coaches, consumer-run centers, narcotic treatment, etc.
70.6	MHSA-12	Reduce the disparities in access to effective, culturally and linguistically competent mental health and substance abuse services among populations of differing races, ethnicities, sexual orientations and Deaf persons.
69.9	SA-5	Increase capacity to provide evidence-based, universal indirect environmental prevention strategies in areas of the state where data indicates there is need including but not limited to rural villages and towns.
69.8	MHSA-5	Increase young adults (age 18-25) and elders (age 60 and over) who receive

Priority Score	Item Category	Item Description
		effective treatment for mental health or substance use disorders. Young adult prevalence rates are higher than average and both groups' rates of receiving treatment are lower than average.
69.1	MH-3	Reduce mental health inpatient readmission rates by increasing the availability of community-based alternatives.
68.8	MHSA-2	Increase veterans, active service members and military families who receive effective treatment for mental health or substance use disorders.
67.1	SA-4	Reduce high usage of detoxification services in areas where usage exceeds the state or national average.
66.6	MHSA-10	Collaboration or integration of substance abuse and mental health services with primary health care to improve overall health outcomes including but not limited to smoking cessation.
63.0	MH-5	Provide parents and helping professionals working with infants and young children (e.g., child care workers, home visitors, and pediatricians) the knowledge, skills, and practices that support healthy social and emotional child development.
55.3	SA-9	Reduce the use of synthetic drugs that have a similar effect as marijuana (spice) or stimulants (bath salts).
51.9	MHSA-7	Address access barriers to pathological gambling disorder treatment in order to increase the number of persons receiving treatment.

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Tuberculosis

Priority Type: SAP

Population (s): TB

Goal of the priority area:

At least 98% of all certified Alcohol and Other Drug Abuse (AODA) treatment agencies in Wisconsin will be compliant with TB screening, information and referral policies and practices.

Strategies to attain the goal:

In cooperation with the Wisconsin Division of Quality Assurance, identify agencies in non-compliance with TB screening, information and referral policies and provide follow-up technical assistance to ensure compliance.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The rate of treatment agencies in compliance with TB screening, information and referral policies vs. total agencies certified or re-certified will be at least 98%.
Baseline Measurement:	There are 650 certified substance abuse service agency sites across Wisconsin that are required to implement communicable disease screening, information and referral. Failure to do so results in a citation issued by our Division of Quality Assurance. Each year 325 sites are visited and/or reviewed. An average of 2 sites (0.6%) received this citation each year for the past 3 years; 99.4% are in compliance.
First-year target/outcome measurement:	Seven or fewer service agency sites (2% or less) receive a communicable disease screening, information and referral citation; 98% are in compliance.
Second-year target/outcome	Seven or fewer service agency sites (2% or less) receive a communicable disease screening,

measurement: information and referral citation; 98% are in compliance.

Data Source:

Wisconsin Division of Quality Assurance (DQA)

Description of Data:

Treatment agency citations issued by DQA staff for violations of TB screening, information and referral policies consist of a letter to the treatment agency describing the violation.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 2

Priority Area: Intravenous Drug Users

Priority Type: SAP

Population (s): IVDUs

Goal of the priority area:

Increase prevention, street outreach and access to recovery-oriented treatment for intravenous drug users (IVDU) by 2%.

Strategies to attain the goal:

1. Realign existing funding to have increased emphasis on prevention and early intervention; provide education and training to street outreach teams.
2. Strengthen collaborations among agencies serving IVDUs.
3. Grant support of the Injection Drug Use Street Outreach program.
4. Monitor intravenous drug use related deaths.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase annual treatment admissions among intravenous drug users (IVDU) by 2%.

Baseline Measurement: An annual average of 1,513 IVDU treatment admissions from 2009-2011.

First-year target/outcome measurement: At least 1,543 annual IVDU treatment admissions, or an increase of at least 2% over baseline.

Second-year target/outcome measurement: At least 1,543 annual IVDU treatment admissions, or an increase of at least 2% over baseline.

Data Source:

Calendar year 2013 and 2014 Program Participation System (PPS) Alcohol/Drug Abuse module which is the statewide data system used to collect and submit Federal Treatment Episode Data Set (TEDS) data.

Description of Data:

Count of admissions that have needle or injection as the route of drug administration.

Data issues/caveats that affect outcome measures::

Data quality and completeness issues will be minimized through data quality control reports and contracts with reporting agencies.

Priority #: 3

Priority Area: Culturally Appropriate and Comprehensive Services for Special Populations

Priority Type: SAP, SAT

Population (s): Other (LGBTQ, Military Families, Asian, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Improve access to recovery-oriented services for special populations such as Hispanic/Latinos, African Americans, Asians, American Indians, Military Families, Deaf and Hard of Hearing, and Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) populations.

Strategies to attain the goal:

1. Regularly monitor treatment services provided to special populations to assure the proportion of racial, ethnic and culturally diverse individuals being served are comparable to the substance abuse prevalence identified in each population.
2. Provide technical assistance to county administrative and community provider agencies to improve access to services for populations with special needs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The proportion of racial, ethnic persons served will be comparable to their substance abuse prevalence. Census data and substance use disorder prevalence data will be used to estimate the minimum proportion of admissions to services that should be racial, ethnic persons. This will be compared to the actual rate of admissions/participation in substance abuse treatment services from PPS/TEDS and Substance Abuse Prevention Services Information System (SAPSIS) data.
Baseline Measurement:	The estimated percent of Wisconsin substance abuse prevalence that are racial/ethnic populations is 13%. The CY 2010 actual percent substance abuse treatment service admissions that are racial/ethnic populations is 18%.
First-year target/outcome measurement:	Percent substance abuse treatment service admissions that are racial/ethnic populations are at or above 14% based upon annual recalculated comparison data.
Second-year target/outcome measurement:	Percent substance abuse treatment service admissions that are racial/ethnic populations are at or above 15% based upon annual recalculated comparison data.

Data Source:

Calendar year 2013 and 2014 PPS Alcohol/Drug Abuse module and CY 2014 SAPSIS data will be utilized.

Description of Data:

County/percent of admissions/participants that are African American, Hispanic/Latino, Asian American, or Native American.

Data issues/caveats that affect outcome measures::

Data quality and completeness issues will be minimzed through data quality control reports and contracts with reporting agencies.

Priority #:	4
Priority Area:	Youth Access to Tobacco Products
Priority Type:	SAP
Population (s):	Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Reduce youth access to tobacco products by maintaining an annual retailer violation/tobacco sell rate to minors of less than 10%.

Strategies to attain the goal:

Continuation of the implementation of the Wisconsin Wins (WI Wins) compliance checks, media outreach and public outreach through the Division of Public Health's Tobacco Prevention and Control Program. There is a 40% funding penalty assessed against the Substance Abuse Prevention and Treatment Block Grant if the tobacco sale rate to minors is over 20%.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The proportion of successful purchases of tobacco products by youth people will be below 10%.
Baseline Measurement:	An average of 5.1% of attempted illegal tobacco sales to minors are completed (2011-2013).
First-year target/outcome measurement:	Less than 10% of attempted illegal tobacco sales to minors are completed.
Second-year target/outcome measurement:	Less than 10% of attempted illegal tobacco sales to minors are completed.

Data Source:

The Synar compliance check effort is coordinated by the Divison of Public Health's Tobacco Prevention and Control Program WI Wins program. Data will be obtained from the program's coordinator from data collected using an approved sampling scheme. Data will also be obtained from the Division of Public Health, Tobacco Prevention and Control Program, the WI Wins program, and the University of Wisconsin Survey Center.

Description of Data:

The University of Wisconsin Survey Center scientifically determines the random sample of retail outlets that will targeted for law enforcement-supervised compliance checks in which minors will attempt to purchase tobacco products. The compliance checks are completed by July each year and the rate of violations data is available in December.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 5

Priority Area: Pregnant Women and Mothers with Dependent Children

Priority Type: SAP, SAT

Population (s): PWWDC, Other (Parents with substance use disorder)

Goal of the priority area:

Increase the number of women specific recovery-oriented, evidence-based services or programs within five counties or tribes with a focus on pregnant women or women with dependent children.

Strategies to attain the goal:

Develop plans, conduct training, provide technical assistance, and implement the use of evidence based practices (EBP) for substance-abusing pregnant women and mothers with dependent children within counties and/or tribes that do not have these services using the following strategies/plans:

1. Outreach to and identification of Counties and/or Tribes
2. Identify stakeholders and leadership group
3. Completion of baseline EBP fidelity/readiness review and summary report of findings
4. Written action plan based upon fidelity measure findings. The action plan should specify measureable EBP implementation objectives going forward that are reported on semi-annually
5. Completion of initial training and on-going technical assistance
6. Client outcomes/perceptions measures and data collection protocols identified and put in place
7. Written agency EBP policies, protocols and service funding mechanisms.
8. First 5-10 clients receive EBP services; evaluate pilot and prepare summary report of findings
9. Make changes in EBP services based upon experience with first 5-10 clients
10. Maintain and monitor EBP services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Record and document progress toward and completion of the identified strategies.

Baseline Measurement: No new counties and/or tribes are receiving planning, training and technical assistance for the implementation of evidence based, women-specific services and approaches.

First-year target/outcome measurement: 5 Counties and/or Tribes complete at least the first 5 identified strategies.

Second-year target/outcome measurement: 2 of the 5 Counties and/or Tribes complete items 6 through 10 of the identified strategies.

Data Source:

Contact records, training and fidelity forms and reports; County and/or Tribal agency client records.

Description of Data:

Administrative and client records.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 6

Priority Area: Substance Abuse Services in the Criminal and Juvenile Justice Systems

Priority Type: SAT

Population (s): SMI, SED, Other (Criminal/Juvenile Justice, Individuals with mental and/or substance use disorders involved in the criminal and juvenile justice systems.)

Goal of the priority area:

Increase the use of effective and recovery-oriented evidence-based services for substance use disorders for persons coming in contact with the criminal and juvenile justice systems.

Strategies to attain the goal:

Develop and provide training and consultation on the expansion of Evidence-Based Practices (EBP) for substance-abusing persons coming in contact with the criminal and juvenile justice systems utilizing the following strategies/plans:
1. Outreach to and identification of Counties and/or Tribes
2. Identify stakeholders and leadership group
3. Initial planning discussions about client target group (age; types of offenses/offenders; pre- or post- trial; etc.), evidence-based practices, and fidelity measure
4. Completion of baseline EBP fidelity review and summary report of findings
5. Written action plan based upon fidelity measure findings. The action plan should specify measureable EBP implementation objectives going forward that are reported on semi-annually

6. Completion of initial training and on-going technical assistance
7. Client outcomes/perceptions measures and data collection protocols identified and put in place
8. Written agency EBP policies, protocols and service funding mechanisms
9. First 10 clients receive EBP services in each justice system; evaluate pilot and prepare summary report of findings
10. Make changes in EBP services based upon pilot experience with first 10 clients
11. Maintain and monitor EBP services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Record and document progress toward, and completion of, the identified strategies.
Baseline Measurement:	No new Counties and/or Tribes are receiving planning, training and technical assistance for the implementation of evidence based practices for substance-abusing persons coming in contact with the criminal and juvenile justice systems.
First-year target/outcome measurement:	2 Counties and/or Tribes complete items 1 – 6 of the identified strategies.
Second-year target/outcome measurement:	2 Counties and/or Tribes complete items 7 - 11 of the identified strategies.

Data Source:

Contact records, training and fidelity forms and records; County and/or Tribal agency client records.

Description of Data:

Administrative and client records.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 7

Priority Area: Adult Binge Drinking

Priority Type: SAP, SAT

Population (s): Other (Individuals with high risk use of substances or with substance use disorders.)

Goal of the priority area:

Reduce adult binge drinking (ages 18-34).

Strategies to attain the goal:

a. Provide Screening, Brief Intervention, Referral to Treatment (SBIRT) direction, training and technical assistance through the Wisconsin Medicaid health home initiative.
b. Through training and other contacts with prevention professionals, develop at least 2 new environmental/policy prevention programs in locations around the state targeted to operating a vehicle under the influence.
c. Begin discussions and develop a plan for collaborative activities with the Wisconsin Department of Transportation to enhance state and local law enforcement capacity to enforce Operating While Under the Influence (OWI) laws and other associated alcohol beverage laws.
d. Work with at least 3 community Alliance for Wisconsin Youth coalitions to promote the following preventative interventions: 1) Implement saturation patrols during targeted time periods such as the post-bar-closing hours; 2) Through contacts with appropriate municipal court system officials, promote the prosecution and adjudication with sanctions of alcohol-related law violations; 3) Implement evidence based “best practices” for local retailers such as elimination of consumption based drink specials, bartender/wait staff/manager/owner training, refusal to serve all patrons under age 21, annual review of ID check procedure, identifying intoxicated patrons in coordination with law enforcement, or off-premises “Class A” retailers agree to restriction on “tastings” and restrictions on POS advertising.
e. Through appropriate activities, implement at least 2 new evidence-based OWI courts or other court-based intervention or diversion programs.
f. Monitor annual adult binge drinking rates through the Wisconsin Behavioral Risk Factor Surveillance Survey (BRFSS).
g. Monitor the 2-year lagged number of alcohol-related motor vehicle fatalities (age 16-34) from the National Highway Traffic Safety Administration’s Fatality Analysis Reporting System (FARS) and The Wisconsin Department of Transportation’s Traffic Crash Facts publication; 2008-2010 average is 219 deaths.
h. Monitor the 1.5-year lagged rate of Wisconsin repeat OWI convictions from the Department of Transportation; 2008-2010 average is 12,273 repeat OWI offenses.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Implement, record and document efforts in each of the five identified binge drinking reduction strategies (a. – e.).
Baseline Measurement:	Efforts are underway but no specific documentation is available. The baseline is none of the 5 identified binge drinking reduction strategies (a. – e.) have been completed.
First-year target/outcome	Completion of at least 2 of the identified binge drinking reduction strategies (a. - e.).

measurement:

Second-year target/outcome measurement: Completion of the remaining 3 identified binge drinking reduction strategies (a. - e.).

Data Source:

Contact records, meeting summaries, work plans and reports.

Description of Data:

Administrative records.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 8

Priority Area: Prescription Drug Abuse

Priority Type: SAP

Population (s): Other (Individuals in need of primary substance abuse prevention.)

Goal of the priority area:

Reduce the non-medical/unauthorized use of prescription opiates.

Strategies to attain the goal:

a. Develop best practices for reducing prescription drug availability including practices for prescribers and dispensers as well as for proper medication disposal and disseminate to prescribers, dispensers and other appropriate officials.
b. Develop awareness resources about the risks of and appropriate actions/interventions for non-medical prescription drug use for parents, youth, patients, and health care providers and disseminate to appropriate organizations and sources.
c. Collaborate with the Wisconsin Department of Safety and Professional Services on the implementation of Wisconsin's Prescription Drug Monitoring Program and track appropriate statistics.
d. Monitor the 2013 and 2015 Wisconsin Youth Risk Behavior Survey for lifetime non-medical use of mood altering prescription drugs; 2007-2011 average is 18.1% of high-school age youth
e. Monitor the 2013-2015 National Survey on Drug Use and Health, Wisconsin estimates, for past year non-medical use of prescription pain killers; 2008-2011 age 12-17 average is 6.7%.

f. Monitor non-medical/unauthorized prescription opiate related deaths.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Record and document efforts in each of the above three identified strategy areas (a.-c.).
Baseline Measurement:	Efforts are underway but no specific documentation is available. The baseline is none of the three identified prescription drug abuse prevention strategies (a. – c.) have been completed.
First-year target/outcome measurement:	Completion of at least one of the identified prescription drug abuse prevention strategies in (a. – c.).
Second-year target/outcome measurement:	Completion of the remaining two identified prescription drug abuse prevention strategies in (a. – c.).

Data Source:

Contact records, meeting summaries, work plans and reports.

Description of Data:

Administrative records.

Data issues/caveats that affect outcome measures::

None known.

Priority #:	9
Priority Area:	Children's Mental Health
Priority Type:	SAT, MHS
Population (s):	SED

Goal of the priority area:

Increase the access and quality of wraparound services for children and youth through the expansion of the number of counties and/or tribes with Coordinated Service Teams (CST) initiatives.

Strategies to attain the goal:

a. Provide additional state budget resources to increase the number of counties and / or tribes covered by CST Initiatives statewide.
b. Provide technical assistance to those areas of the state/tribes without CST initiatives.
c. Review data on child and family outcomes of CST initiatives and identify quality improvement objectives.
d. Explore ways to expand child psychiatry consultation for children served by CST initiatives.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The percentage of counties and/or tribes having implemented children's wraparound initiatives will increase by 4% annually. Numerator: Number of counties and tribes with children's wraparound initiatives in FFY 2013. Denominator: Number of counties and tribes in Wisconsin.
Baseline Measurement:	2013: 52 counties and tribes with wraparound initiatives / 83 total counties and tribes = 63%
First-year target/outcome measurement:	2014: 56 counties and tribes with wraparound initiatives / 83 total counties and tribes = 67%
Second-year target/outcome measurement:	2015: 59 counties and tribes with wraparound initiatives / 83 total counties and tribes = 71%

Data Source:

Department funding information for wraparound programs.

Description of Data:

Since this indicator is simply a number of initiatives, data is collected from an administrative list of counties and tribes that have ever received State support to implement a wraparound initiative and have maintained that initiative. The 2012 indicator includes 44 existing county CST's, 6 existing tribal CST's, and 2 other wraparound programs (Dane, Milwaukee).

Data issues/caveats that affect outcome measures::

The ultimate goal for Wisconsin is to expand programs using a wraparound approach in all counties/tribes statewide. Thus, to best reflect progress towards that goal, the indicator is stated as the percentage of all counties/tribes because it illustrates state coverage more effectively than the number of all counties. Not all programs serving children are funded through the Mental Health Block Grant. The two largest counties sustain their children's wraparound initiatives solely through Medicaid and county

funds. These county programs are included in this indicator in addition to counties/tribes receiving CST initiative grants from the State of Wisconsin.

Priority #: 10

Priority Area: Improve mental health and substance abuse service outcomes and quality of care.

Priority Type: SAT, MHS

Population (s): SMI, SED

Goal of the priority area:

Improve access and quality of recovery-oriented mental health and substance abuse services for adults, youth and children that promote evidence-based practices through increasing the number of people served in psychosocial rehabilitation programs, such as Comprehensive Community Services (CCS), Community Support Programs (CSP), Community Recovery Services (CRS), peer support, and supported employment.

Strategies to attain the goal:

a. Expand budget authority for Comprehensive Community Services (CCS) thru Governor's budget initiative for the state to assume nonfederal share of MA.
b. Work with counties and tribes to develop CCS programs in all areas of the state.
c. Develop and monitor performance indicators for CCS programs; implement quality improvement projects as needed in areas needing performance improvement.
d. Promote in CCS/CSP service arrays Peer Specialists, Supported Employment, and Family Psycho-education in order to meet individual needs using these EBPs.
e. Research and develop Peer Run Respite and Warm Lines.
f. Support Peer Run Recovery Centers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of persons served through CCS and CSP programs will increase by at least 2% annually. Numerator: Number of persons served by CCS and CSP programs in SFY2014 - Number of persons served by CCS and CSP programs in SFY2013. Denominator: Number of persons served by CCS and CSP programs in SFY2013

Baseline Measurement: SFY2013: 6,470 persons served by CCS and CSP in SFY2013

First-year target/outcome SFY2014: 129 additional persons served by CCS and CSP / 6,470 persons served by CCS and

measurement:	CSP in SFY2013, at least a 2% increase.
Second-year target/outcome measurement:	SFY 2015: 132 additional persons served by CCS and CSP / 6,599 persons served by CCS and CSP in SFY2014, at least a 2% increase.

Data Source:

Medicaid fee-for-service claims data

Description of Data:

Medicaid claims data. This data contains the most complete count of persons receiving Medicaid benefits like CCS and CSP because the data is used for billing reimbursement. The SFY2013 data was not complete at the time of the grant deadline, but the figure will be updated at a later date.

Data issues/caveats that affect outcome measures::

None known.

Priority #: 11

Priority Area: Mental health services in the criminal justice system

Priority Type: MHP, MHS

Population (s): SMI, SED

Goal of the priority area:

Increase the use of effective and recovery-oriented evidence-based services for mental illness for persons coming in contact with the criminal and juvenile justice system.

Strategies to attain the goal:

Develop and provide training and consultation on the expansion of Evidence-Based Practices (EBP) for persons with mental illness coming in contact with the criminal and juvenile justice system utilizing the following strategies/plans:
1. Outreach to and identification of Counties and/or Tribes
2. Identify stakeholders and leadership group
3. Initial planning discussions about client target group (age; types of offenses/offenders; pre- or post- trial; etc.), evidence-based practices, and fidelity measure

4. Completion of baseline EBP fidelity review and summary report of findings
5. Written action plan based upon fidelity measure findings. The action plan should specify measureable EBP implementation objectives going forward that are reported on semi-annually
6. Completion of initial training and on-going technical assistance
7. Client outcomes/perceptions measures and data collection protocols identified and put in place
8. Written agency EBP policies, protocols and service funding mechanisms
9. First 10 clients receive EBP services in each justice system; evaluate pilot and prepare summary report of findings
10. Make changes in EBP services based upon pilot experience with first 10 clients
11. Maintain and monitor EBP services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Record and document progress toward, and completion of, the identified strategies.
Baseline Measurement:	No new Counties and/or Tribes are recieving planning, training and technical asistance for the implementation of evidence based practices for persons with serious mental illness coming in contact with the criminal and juvenile justice systems.
First-year target/outcome measurement:	2 Counties and/or Tribes complete items 1 - 6 of the itendified strategies.
Second-year target/outcome measurement:	2 Counties and/or Tribes complete items 7-11 of the identified strategies.

Data Source:

Contact records, training and fidelity forms and records; County and/or Tribal agency client records.

Description of Data:

Administrative and client records.

Data issues/caveats that affect outcome measures::

None.

Priority #: 12

Priority Area: Suicide Prevention

Priority Type: MHP

Population (s): SMI, Other (Military Families)

Goal of the priority area:

Reduce the rate of suicide in Wisconsin, including but not limited to persons age 50-59, service members and veterans.

Strategies to attain the goal:

a. Collaborate with public and private stakeholders to develop and disseminate a state suicide prevention plan for Wisconsin.
b. Foster development of local suicide prevention coalitions by creating and disseminating a tool by which a coalition's level of functioning can be measured. Functioning will be measured in regard to membership, activities conducted and an evaluation of effectiveness.
c. Promote public awareness and education through gatekeeper training in assessing for risk of suicide and encouraging appropriate professional help.
d. Investigate and expand systems change approaches in health care settings to strengthen the idea that suicide can be prevented.
e. Support development of the mental health workforce through training in recognizing, assessing, managing and responding to suicide risk.
f. Monitor mental health data and risk factors of suicide through the annual Wisconsin Behavioral Risk Factor Survey (BRFS), including rates of hopelessness and depression.
g. Monitor annually the 2-year lagged rates of suicide at the national, state and county levels through WISH (Wisconsin Interactive Statistics on Health) and WISQARS (Web-based Injury Statistics Query and Reporting System).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Implement, record and document efforts in each of the five identified strategies (a. – e.).
Baseline Measurement:	Efforts are underway, but no specific documentation is available. None of the five suicide prevention strategies (a. –e.) have been completed.
First-year target/outcome measurement:	Completion of at least two of the identified suicide prevention strategies (a. – e.).
Second-year target/outcome measurement:	Completion of the remaining three identified suicide prevention strategies (a. – e.).

Data Source:

Contact records, meeting summaries, work plans and reports.

Description of Data:

Administrative records.

Data issues/caveats that affect outcome measures::

None known.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$43,143,774		$104,300	$4,182,900	$3,885,600	$	$
a. Pregnant Women and Women with Dependent Children*	$ 7,226,722		$	$	$ 701,900	$	$
b. All Other	$ 35,917,052		$ 104,300	$ 4,182,900	$ 3,183,700	$	$
2. Substance Abuse Primary Prevention	$ 11,749,080		$	$ 2,377,100	$ 3,313,100	$	$
3. Tuberculosis Services	$		$	$	$ 596,200	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 187,400		$	$	$ 358,800	$	$
11. Total	$55,080,254	$	$104,300	$6,560,000	$8,153,700	$	$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$	$	$ 234,091,60	$	$ 344,800
6. Other 24 Hour Care		$	$	$	$	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 10,545,882	$ 744,300	$ 600,000	$ 29,430,800	$	$
8. Mental Health Primary Prevention		$ 358,600	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$ 2,665,724	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 74,200	$	$	$	$	$
11. Total	$	$13,644,406	$744,300	$600,000	$263,522,400	$	$344,800

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
Specialized Outpatient Medical Services	0	0.00	$	$
Acute Primary Care	0	0.00	$	$
General Health Screens, Tests and Immunizations	0	0.00	$	$
Comprehensive Care Management	0	0.00	$	$
Care coordination and Health Promotion	0	0.00	$	$
Comprehensive Transitional Care	0	0.00	$	$
Individual and Family Support	0	0.00	$	$
Referral to Community Services Dissemination	0	0.00	$	$
Prevention (Including Promotion)			$	$
Screening, Brief Intervention and Referral to Treatment			$	$

Brief Motivational Interviews			$	$
Screening and Brief Intervention for Tobacco Cessation			$	$
Parent Training			$	$
Facilitated Referrals			$	$
Relapse Prevention/Wellness Recovery Support			$	$
Warm Line			$	$
Substance Abuse (Primary Prevention)			$	$
Classroom and/or small group sessions (Education)			$	$
Media campaigns (Information Dissemination)			$	$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$	$
Parenting and family management (Education)			$	$
Education programs for youth groups (Education)			$	$
Community Service Activities (Alternatives)			$	$
Student Assistance Programs (Problem Identification and Referral)			$	$
Employee Assistance programs (Problem Identification and Referral)			$	$

Community Team Building (Community Based Process)			$	$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$	$
Engagement Services			$	$
Assessment			$	$
Specialized Evaluations (Psychological and Neurological)			$	$
Service Planning (including crisis planning)			$	$
Consumer/Family Education			$	$
Outreach			$	$
Outpatient Services			$	$
Evidenced-based Therapies			$	$
Group Therapy			$	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers			$	$
Medication Services			$	$

Medication Management			$	$
Pharmacotherapy (including MAT)			$	$
Laboratory services			$	$
Community Support (Rehabilitative)			$	$
Parent/Caregiver Support			$	$
Skill Building (social, daily living, cognitive)			$	$
Case Management			$	$
Behavior Management			$	$
Supported Employment			$	$
Permanent Supported Housing			$	$
Recovery Housing			$	$
Therapeutic Mentoring			$	$
Traditional Healing Services			$	$
Recovery Supports			$	$
Peer Support			$	$
Recovery Support Coaching			$	$

Recovery Support Center Services			$	$
Supports for Self-directed Care			$	$
Other Supports (Habilitative)			$	$
Personal Care			$	$
Homemaker			$	$
Respite			$	$
Supported Education			$	$
Transportation			$	$
Assisted Living Services			$	$
Recreational Services			$	$
Trained Behavioral Health Interpreters			$	$
Interactive Communication Technology Devices			$	$
Intensive Support Services			$	$
Substance Abuse Intensive Outpatient (IOP)			$	$
Partial Hospital			$	$

Assertive Community Treatment			$	$
Intensive Home-based Services			$	$
Multi-systemic Therapy			$	$
Intensive Case Management			$	$
Out-of-Home Residential Services			$	$
Children's Mental Health Residential Services			$	$
Crisis Residential/Stabilization			$	$
Clinically Managed 24 Hour Care (SA)			$	$
Clinically Managed Medium Intensity Care (SA)			$	$
Adult Mental Health Residential			$	$
Youth Substance Abuse Residential Services			$	$
Therapeutic Foster Care			$	$
Acute Intensive Services			$	$
Mobile Crisis	0	0.00	$	$
Peer-based Crisis Services	0	0.00	$	$

Urgent Care	0	0.00	$	$
23-hour Observation Bed	0	0.00	$	$
Medically Monitored Intensive Inpatient (SA)	0	0.00	$	$
24/7 Crisis Hotline Services	0	0.00	$	$
Other (please list)			$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 21,571,887	
2 . Substance Abuse Primary Prevention	$ 5,874,540	
3 . Tuberculosis Services	$	
4 . HIV Early Intervention Services**	$	
5 . Administration (SSA Level Only)	$ 93,700	
6. Total	$27,540,127	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

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III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 1,938,598	$2,221,581
Universal Indirect	$ 881,181	$965,213
Selective	$ 1,762,362	$2,001,585
Indicated	$ 1,292,399	$1,465,421
Column Total	$5,874,540	$6,653,800
Total SABG Award*	$27,540,127	
Planned Primary Prevention Percentage	21.33 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Note: The current information in the FY 2015 column was entered based on early calculations. As the FY 2015 column is locked in WebBGAS, Wisconsin is unable to remove or update this infomation. Wisconsin requests that the FY 2015 information be removed as it is no longer accurate.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	¢
Prescription Drugs	þ
Cocaine	¢
Heroin	þ
Inhalants	¢
Methamphetamine	þ
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	þ
Military Families	þ
LGBTQ	¢
American Indians/Alaska Natives	þ
African American	þ
Hispanic	þ
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	þ
Rural	þ
Underserved Racial and Ethnic Minorities	þ

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 25,000	$ 96,274	$	$121,274	$25,000			$25,000
2. Quality Assurance	$	$ 79,628	$	$79,628				
3. Training (Post-Employment)	$ 7,000	$ 191,188	$	$198,188	$7,000			$7,000
4. Education (Pre-Employment)	$	$	$	$				
5. Program Development	$ 125,900	$ 1,303,568	$	$1,429,468	$25,900			$25,900
6. Research and Evaluation	$ 36,500	$ 108,474	$	$144,974				
7. Information Systems	$ 14,038	$ 43,000	$	$57,038	$14,038			$14,038
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$	$	$				
9. Total	$208,438	$1,822,132	$	$2,030,570	$71,938			$71,938

Footnotes:

Note: The current information in the FY 2015 columns was entered based on early calculations. As the FY 2015 column is locked in WebBGAS, Wisconsin is unable to remove or update this infomation. Wisconsin requests that the FY 2015 information be removed as it is no longer accurate.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$
MHA Administration	$
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$
MHA Activities Other Than Those Above	$
Total Non-Direct Services	$0
Comments on Data:	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

Section IV: Narrative Plan

C. Coverage M/SUD Services

Please refer to the attached table (Appendix 2) in response to question one.

Wisconsin will have a federally facilitated marketplace. It is unclear whose responsibility it would be to monitor Qualified Health Plans (QHP) and access to services.

However, during this past year, the Bureau of Prevention Treatment and Recovery (BPTR) undertook a comprehensive Needs Assessment that included efforts to assess the degree to which individuals received any mental health or substance abuse treatment service in Medicaid Fee for Service, Managed Care Programs and public county services. The Needs Assessment includes a treated prevalence rate for County provided and Medicaid beneficiaries. The BPTR will consider using this approach for monitoring access to services for the Mental Health (MH) and Substance Use Disorder (SUD) populations in Medicaid and County provided service delivery systems. The BPTR also has recently received access to data from the Wisconsin Health Information Organization (WHIO) that is a Health Information Exchange covering approximately 75% of individuals in the state covered by either public or private insurance, primarily in the Southeastern part of the state. The BPTR Evaluation staff will continue to investigate the capacity of this system to monitor access to mental health and substance abuse services for the privately insured population, including the Qualified Health Plans if they report data into the WHIO.

In response to question four, in Wisconsin, the Office of the Commissioner of Insurance is responsible for any complaints or violations of insurance laws. To date, the State Mental Health Authority (SMHA)/Single State Authority for substance abuse (SSA) has not been involved. It is still too early to know about the impact of the Marketplace mental health and substance abuse Qualified Health Plan coverage and exclusions in Wisconsin. A major portion of the Block Grants go to county agencies. The state contracts with county agencies that are already responsible under state law for those individuals who do not have access to mental health and substance abuse services thru health insurance (under insured) or for those without any health insurance coverage. Since this will be the same target population post Affordable Care Act (ACA), the impact remains unclear. Wisconsin counties already contribute a considerable amount of local county tax levy for mental health and substance use services for these individuals and many counties report a waiting list for services.

In addition, the primary target populations served by counties are individuals involved in court systems, such as Intoxicated Driving or who have been picked up on an emergency detention in the area of mental health, as well as those individuals who may be poor and who do not at the point of contact have health insurance coverage. Many of the services needed by individuals with serious mental illness, such as psychosocial rehabilitation benefits, are not typically covered by commercial insurance packages. The state needs more information on what, if any, psychosocial rehabilitation benefits will be required for Wisconsin for the Marketplace population. Counties currently must pay the non-federal share of the Medicaid expenditures for psycho-social rehabilitation services. The expansion of Medicaid wouldn't reduce those expenditures; instead it would put greater pressure on counties for additional referrals for those services.

As the number of people gain access to health insurance, it is hoped that with greater access to health insurance and parity, the system may begin to be more responsive, with individuals accessing treatment in a timelier manner, and reducing the long term impact. However, the timing of this transition is still very unclear.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

Section IV: Narrative Plan

D. Affordable Insurance Marketplace

In response to question one, the Bureau of Prevention, Treatment and Recovery (BPTR) has included information on treated prevalence in its recent needs assessment and will anticipate using this method in the future to monitor trends in access to behavioral health services (Appendix 1).

In response to question two, more information is needed from the federal government about how the Navigator program will work in Wisconsin.

In response to question three, the state will explore changing its contractual language with county-based and other providers to explicitly state that Block Grant dollars are to be used only after such screening, enrollment assistance, and billing of appropriate insurance has taken place.

In response to question four, Wisconsin has opted for a Federally-facilitated Marketplace, and thus the Marketplace will be responsible for certification (including recertification and decertification), management, and oversight of QHPs. The state has expressed its concern about a lack of information from the federal government related to Marketplace implementation. That uncertainty notwithstanding, the state will continue to perform its traditional regulatory role with regard to providers and health plans.

In calculating an estimate of the number of uninsured individuals served under the MHBG and SABG in CY 2013 it should be noted that the MHBG and SABG also serves people who may have health insurance but who are underinsured for treatments needed by individuals with serious behavioral health disorders such as psychosocial rehabilitation and residential treatment services. In Wisconsin the majority of funding from the MHBG and SABG already are targeted to populations and services not typically funded by insurance plans: individuals referred thru court systems and emergency detentions. Another pertinent factor is Wisconsin's county-based systems often report all individuals served, not those just served by the block grant funding. As such, estimates of the number of persons served in Wisconsin often include individuals served by counties and paid for by Medicaid, private insurance and through county tax levy.

The following response addresses both questions 5 and 6 with regard to individuals served under the MHBG and SABG who are uninsured in CY 2013, CY 2014, and CY 2015. For CY 2013, it is estimated that 26,244 individuals reported to be served by counties under MHBG are uninsured and 23,569 individuals served under the SABG are uninsured. For CY 2014, it is estimated that 23,384 individuals served under the MHBG will remain uninsured and 20,788 individuals served under the SABG will remain uninsured. For CY 2015, the estimates are that 23,150 and 20,372 individuals served under the MHBG and SABG, respectively, will remain uninsured. Below is a discussion of the assumptions and methodology used to develop these estimates, which, it should be noted, are conservative estimates.

In a national study, 43% of adults with mental health or substance use conditions have incomes less than 150% of the federal poverty income level indicating a high need for public support for services. A more precise question is, if 100 people from the general population sought treatment for a mental health or substance use condition, what proportion of them would be the responsibility of the publicly-financed system? The National Survey on Drug Use and Health derives national estimates to answer this question from survey respondents who had sought treatment. Wisconsin's 2008 low income rate (having less than 185% of the federal poverty income level) is fairly close to the national average (WI 23.4% vs. U.S.

27.7%) so these national estimates are applied to Wisconsin with some caution. The results are presented in the following table:

Consumer-reported Source of Payment for

Mental Health and Substance Abuse Treatment

	Mental Health	Substance Abuse
Medicaid	**10%**	**15%**
Other federal, state or local funds	**21%**	**39%**
Subtotal public system	**31%**	**54%**
Private insurance	**42%**	**23%**
Medicare	**12%**	**12%**
Self-pay	**15%**	**11%**
Subtotal private system	**69%**	**46%**

Source: National Survey on Drug Use and Health (2007-2008).

Therefore, it is estimated that a minimum of 36% (21%+15%) of individuals served under the Mental Health Block Grant are uninsured and a minimum of 50% (39% + 11%) of individuals served under the Substance Abuse Block Grant are uninsured. Applying these factors to the number of persons served under the block grants in 2011 yields our estimate:

2011
Mental Health: 73,636 x.36 = 26,509 individuals served under the MHBG who are uninsured

Substance Abuse: 48,100 x .50 = 24,050 individuals served under the SABG who are uninsured

Assumptions
The federal health insurance Marketplace and health insurance requirement are set to take effect in 2014. It is anticipated that the number of insured individuals in Wisconsin will increase as a result. Wisconsin's current population is 5,686,986 persons; the current rate of health insurance for non-elderly adults and children is estimated at 89%. In 2014, Wisconsin anticipates that the number of insured non-elderly adults will increase to 93% and the number of insured children will increase to slightly over 95%. In total, Wisconsin estimates an approximate overall 4.5% increase in the insured rate for adults and children. Currently, the number of persons served under the block grants is declining slightly from year-to-year.

Below is the methodology and projections of Block Grant uninsured persons for 2013, 2014, and 2015:

2013
Mental Health: 2011 baseline 26,509 – 1% (declining admissions) = 26,244 uninsured

Substance Abuse: 2011 baseline 24,050 – 2% (declining admissions) = 23,569 uninsured

2014
Mental Health: 2013 baseline 26,244 – 1% (declining admissions) = 25,982 – 4.5 % (decrease in uninsured persons) = 24,813 uninsured

Substance Abuse: 2013 baseline 23,569 – 2% (declining admissions) = 23,098 – 4.5% (decrease in uninsured persons) = 22,059 uninsured

2015
Mental Health: 2014 baseline 24,813 – 1% (declining admissions) = 24.565 uninsured
Substance Abuse: 2014 baseline 22,059 – 2% (declining admissions) = 21,618 uninsured

In response to questions seven and eight, Wisconsin currently has no report that can generate the information requested. In Wisconsin, individual professional providers have Medicaid billing numbers and may directly bill Medicaid for outpatient services. In addition, some services also require an agency billing number. The lists in Table 8 are listed only as provider agencies. To compound the complexity, many of the county intermediaries in Table 8, contract with a wide variety of providers for mental health and substance abuse services, instead of providing the services directly. Many of the providers they contract with do bill for Medicaid services, but there is no way to estimate how many.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

Section IV: Narrative Plan

E. Program Integrity

Wisconsin will not implement its own health Marketplace; however, starting in CY 2013 Wisconsin has begun a three-year pilot project with two consortiums of county governments to develop regional collaborative development of shared mental health and substance abuse services. These contracts are funded by the mental health block grant (MHBG) and the substance abuse block grant (SABG). A key element of these contracts will be development of a set of core benefits for mental health and substance abuse services and other policy initiatives to ensure our BG funding will be used to effectively and efficiently to provide services not funded thru the Affordable Care Act.

The SSA/SMHA has the overall responsibility for the state agency's program integrity activities. The Wisconsin Department of Health Services' (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) has established a workgroup that meets once every two weeks to review and improve Divisional procurement processes including request for proposals and contracting. One product of this workgroup has been the development of a standard exhibit for all SABG funded Requests for Proposals (RFP) and contracts that identifies all federal compliance provisions to assure program integrity. Broader efforts to insure block grant program integrity have been implemented including a standard excel budget for contractors and uniform practices for staff drafting RFPs and scoring RFP submissions.

BG budget review monitoring and oversight responsibilities on the state budget appropriation level are primarily assigned to the community program Budget and Policy Analyst in the DMHSAS of the DHS. This position provides quarterly projections of BG award balances to DMHSAS managers including the Director of the Bureau of Prevention Treatment and Recovery (BPTR) who is the SSA/SMHA.

Funding of the State BG Plan is reviewed annually with the Wisconsin Council on Mental Health and the State Council on Alcohol and Other Substance Abuse. These plans include brief descriptions and amounts for planned contracts and relate the purpose of contracts with the policy goals of each block grant. In addition, the same funding plan are reviewed and approved by the Secretary's Office of DHS. Any substantial change in these plans are also reviewed and approved by the same parties.

Contracts include an individual budget which is reviewed and approved by the Contract Administrator assigned to each contract, the Division's Contract Specialist, the community program Budget and Policy Analyst, an appropriate Section Supervisor, and the BPTR Director. The purpose of the review is to assure that all contract expenditures as described in narrative format, are consistent with the purpose of each contract, the planned expenditures BG requirements and rules. Attached to all contracts with SABG funding is a detailed list of allowable costs under the BG that is provided to all contractors. A similar list of SABG provisions is annually reviewed and stipulated to by all counties receiving block grant funding. In addition, each county is required to report annually on the BG funding which is expended on primary prevention to assure compliance with the 20% primary prevention expenditure requirement under the BG.

Wisconsin does not use an insurance claims model for distributing BG funding. Instead individual contracts are utilized to distribute BG funding. Questions of payment processes under these contracts are addressed by Division managers, DHS Bureau of Fiscal Services staff, and Division's Contract Specialist and the Division community program Budget and Policy Analyst.

On a monthly basis the Division's community program Budget and Policy Analyst/Contract Specialist produces an excel spreadsheet summary of the financial status of all block grant-funded contracts that is distributed to BPTR supervisors and the BPTR Director. The report notes if individual BG contracts have

failed to expend funding in a timely manner. This report is reviewed in monthly meetings in which supervisors designate contract administrators to investigate and contact contract agencies that have failed to expend funds in a timely manner.

On a quarterly basis the Division's community program Budget and Policy Analyst updates obligation spreadsheets that detail the planned contract and operational expenditures for each block grant award, the contracts obligated and contracts expended. These obligation spreadsheets are reviewed in detail with the BPTR director and supervisors and the Deputy Division Administrator.

On an annual basis contract administrators perform field visits with agencies receiving BG funding. During these visits the contractor administrator reviews agency work plans submitted in BG contracts reviews the agencies progress and adherence to the work plans. Additionally, the contract administrator reviews compliance with SABG and MHBG funding requirements. The content of these reviews are discussed with the administrator's supervisor and the Bureau Director and a corrective action plan is drafted to address non-compliance with contract mandates. If the remedial action plan is not adequately addressed by the contractor the contract will not be renewed.

Encounter, utilization, and performance analysis reports are created to analyze block grant funded agency process using the Program Participation System (PPS) and Substance Abuse Prevention Services Information System (SAP-SIS) data systems by Bureau staff. These reports are reviewed by Division data specialists, contract administrators, supervisors, and the Bureau Director. The results of these reports are also incorporated into a Division wide annual performance report.

Agencies receiving block grant contract awards of $25,000 or more are required to submit single agency audit reports to Department staff that include a review of adherence to federal block grant requirements. These reports are reviewed by personnel in the DHS Office of Inspector General (OIG). Any findings of significance are passed along to Division's Bureau Director and community program Budget and Policy Analyst. These findings are discussed with the contract administrator and his or supervisor who lead an investigation of the findings and develop a corrective action or response plan. If the agency succeeds in adequately addressing the finding issues the Division's approves it and signs off on the audit with OIG.

The community Budget and Policy Analyst assures compliance with DHS accounting manual standards and federal block grant standards during the review process of individual contract budgets. Each contract is also reviewed by BPTR supervisors, the BPTR Director, and the community Budget and Policy Analyst to assure compliance with Block Grant funding restrictions and the appropriateness of payments for the type and quantity of services provided. Areas of particular review are the appropriateness of any computer/software purchases, travel costs by contractor staff, and indirect cost charges.

The Division has concentrated much of its MHBG funding on developmental grants rather than direct services provisions. In addition, direct service grants under SABG are serving populations that are not likely to be Medicaid or private insurance eligible and/or would not have the services we support paid by Medicaid or private insurance.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

Section IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

The Integrated Services Section, within the Bureau of Prevention Treatment and Recovery (BPTR), has the task of providing training, technical assistance, and quality improvement within the mental health and substance abuse service system. Currently, the section provides training on the following evidence based practices:

- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Motivational Interviewing
- Evidenced Informed Person Centered Planning.

In addition, the Section provides funding for and promotes the use of the evidence based practices:

- Supported employment model of Individual Placement and Services (IPS)
- Peer support practices
- Integrated Dual Disorder Treatment (IDDT)
- Wrap around practices, including for transitional age youth.
- Teen Intervene

Additionally, the Section provides training and technical assistance with regard to Trauma Informed Care. The Substance Abuse section provides training and technical assistance in the following evidence based practices: drug courts, medication assisted treatment, and women's specific treatment. The Mental Health Services section provides technical assistance on Assertive Community Treatment (ACT), and crisis intervention and stabilization services.

At this time, policy decisions are made to incorporate evidence based, or promising practices, in the majority, if not all, of our training and technical assistance statewide. System transformation efforts are examined with the knowledge that evidence based practices can increase quality and efficiencies in systems and produce better outcomes. Any contract that is issued with regard to the incorporation of an evidence based practice into the system contains a contractual obligation that the contractee adhere to fidelity of the evidence based practice.

Additionally, the Bureau has provided education to Wisconsin's county based mental health and substance abuse system and providers about the effectiveness of evidence based practices and the need to incorporate into existing practices. The Bureau has also utilized educational information in an attempt to inform state policy makers of the advantages and the need to include evidence based practices in Wisconsin's mental health and substance abuse services system.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

Section IV: Narrative Plan

H. Trauma

Wisconsin Trauma Informed Care Initiative
In 2007, the Wisconsin Department of Health Services (DHS) along with other stakeholders, hosted a state trauma summit. Since that time, Wisconsin has rapidly increased Trauma Informed Care (TIC) capacity. A portion of the Wisconsin block grant is used to fund the TIC Consultant position and activities related to the implementation of TIC within mental health and substance abuse services, as well as within other state systems such as the Department of Corrections (DOC), Department of Public Instruction (DPI), and the Department of Children and Families (DCF). The initiative incorporates an understanding of trauma's impact, including the consequences and the conditions that enhance healing in all aspects of service delivery. The TIC Consultant is housed in the Bureau of Prevention Treatment and Recovery (BPTR) and employed through a contract with the University of Wisconsin (UW) Department of Psychiatry. She provides administrative and service-level technical assistance leading to TIC modifications in organizational operations and service provision. Additionally, the TIC Consultant staffs the state-wide TIC Advisory Committee; facilitates and manages the statewide TIC list serve now with over 1050 enrolled participants; trains and provides technical assistance to systems, organizations, and groups that are interested in TIC transformation; assists in the Bureau's initiative to reduce the use of seclusion and restraint in human service systems; provides expert TIC guidance to the DHS, the DCF, the DOC, and the DPI. The adoption of TIC is largely the result of an engaged consumer base and willing provider partners.

Policies in Administrative Rule
Outpatient clinics overseen by the DHS are specifically directed to use, "techniques for assessing and responding to the needs of consumers who appear to have problems related to trauma; abuse of alcohol, drug abuse or addiction; and other co−occurring illnesses and disabilities." Within Wisconsin's Comprehensive Community Services (CCS) program under the Medicaid benefit, there are also requirements for orientation and training around trauma. Moreover, within both Outpatient Mental Health Clinic and CCS standards, assessment of trauma and significant life stressors is required. Trauma and life stressors are also an assessment domain in the Community Recovery Services (1915i) benefit. Presently there are no directives requiring providers use trauma-focused therapies. However, with the State's focus on TIC, providers are increasingly offering evidence-based, trauma specific interventions to satisfactorily meet the needs of mental health and substance use disorder consumers. For example, the northwest region of Wisconsin has child therapists trained in Trauma-Focused Cognitive Behavioral Therapy; many Milwaukee providers have been trained in Parent Child Interaction Therapy; and providers across the state report using a Seeking Safety curriculum to address trauma and substance use disorder.

TIC Objectives:

- Disseminate the trauma-informed care values and practices statewide.
- Staff Trauma-Informed Care Advisory Committee (TIC AC) meetings.
- Identify, train and support TIC Champions and developing TIC organizations.

Outreach Across Systems
Essential to promotion of these statewide objectives is cross-systems' TIC exposure and engagement. To date, with consultation and leadership from the TIC Consultant, the DPI, the DOC, and the DCF have incorporated TIC into staff training and have begun implementation of action steps. Several of these steps include the following: the DPI developed TIC tools to be distributed to Wisconsin schools which are located on their *Creating Trauma Sensitive Schools* website, a TIC focused child welfare (DCF) leadership committee which includes the First Lady of Wisconsin and Casey Family Programs, actively

promotes TIC transformation and trauma-specific interventions across child-serving systems. Robert Anda, co-principal investigator for the *Adverse Childhood Experience* (*ACE*) Study, presented ACE material to cabinet leadership at a dinner held at the Executive Residence and hosted by Wisconsin's First Lady, and collaborative partners purchased the *2010 Adverse Childhood Experience* (*ACE*) module which was included in that year's Wisconsin *Behavioral Risk Factor Survey*. The resulting data was published by the Wisconsin Children's Trust fund in January, 2012.

Consumer Involvement
Assertive efforts to assure meaningful consumer involvement are a part of the TIC initiative in Wisconsin. TIC has become a central theme included in consumer conferences and peer specialist trainings. A group of TIC trained peer leaders are regularly asked to present TIC concepts to a wide range of consumer and provider groups and are paid for their time and knowledge.

In order to develop more TIC trainers and consultants, several youth residential service organizations have received more intensive TIC training and technical assistance. In return, leadership from these organizations has agreed to assist other organizations in their transformations. The TIC Consultant also provided training and technical assistance to Wisconsin Women's Resource Center, a newly established trauma-informed unit within Wisconsin's only prison/mental health institution. Additional training and technical assistance was provided to over 2,600 individuals represented from the following groups:

DHS/DCF	*(# of people served)*
• County Human Service Providers from across the state	555
• Transition-Youth Providers	25
• Children Come First Conference	40
• Youth Residential Care	405
• WI Tribal Communities	100
• Milwaukee Co-Occurring Work Group	50
• OARS, DMHSAS	40
DHS/DOC	
• Wisconsin Women's Resource Center	210
• Taycheedah (Women's Correctional Facility)	40
• Sand Ridge Secure Treatment Center	40
DPI	
• Madison Metropolitan School District	45
Misc.	
• Various Consumer Run Organizations and Peer Specialists	100
• Mental Health America Suicide and TIC (webinar)	
• Rock County Youth Emotional Support	350
• Set Ministry	45
• UW Madison Psychiatric Residents	4
• Wrap Around Dane County	45
National	
• Congressional Briefing on the impact of child abuse/neglect	50
• Unconvention, Pacific Grove, CA	50
• SAMHSA Summit	
• Federal Roundtable on Women and Trauma	
• Georgetown Dept. of Family Medicine	

- Philadelphia Health Federation
- National State's ACE toolbox (Iowa)
- Buffalo, New York (community organizations)

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

Section IV: Narrative Plan

I. Justice

The Division of Mental Health and Substance Abuse Services (DMHSAS) has been regularly sharing information as developments unfold with our criminal justice partners and behavioral healthcare providers. The Division has conducted a survey to determine the capacity of the current workforce to aid in planning initiatives that will help address gaps and prepare providers to bill insurance for substance abuse treatment with an increased emphasis on Master degreed professionals.

The DMHSAS is involved in a wide array of initiatives aimed at addressing the high prevalence of mental health and/or substance abuse disorders of persons within the criminal justice system. Due to the number of interfaces within the criminal justice system for persons with behavioral health needs, the DMHSAS' initiatives include pre-adjudication services, problem solving courts, diversion and re-entry programs, alternatives to revocation, and the operation and management of our state mental health institutes and facilities (more detailed information follows). There is an emphasis on community based treatment alternatives that are based within a framework that persons in the criminal justice system have multiple needs and face a range of behavioral, social, economic and personal challenges that can be obstacles to their success in becoming positively contributing members of our communities.

The Division maintains a strong focus on the promotion and provision of training for the criminal justice and treatment systems on best practice initiatives that are person centered and trauma informed which use motivational, cognitive behavioral and other evidenced based approaches. Department of Correction's (DOC) juvenile division has been partnering with the division's consultant on trauma informed care (TIC) to transform their culture of care, modify policies and practices, integrate trauma specific interventions, and support family involvement. There is also an emphasis on the development and use of peer specialists and recovery coaches. The Wisconsin Conditional Release program has incorporated peer support specialists that assist participants in vocational and meaningful activities, linking with community resources, medication monitoring and assistance with things like shopping and learning how to use the bus system. A recovery coach position was also developed in the Eau Claire County Treatment Alternatives Program (TAP) to help meet participants' needs in the areas of leisure/recreation, social isolation/adjustment, and vocation/education.

DMHSAS has several partnerships with the Department of Corrections (DOC) including a new funding collaboration of two Operating While Intoxicated (OWI) problem solving court pilot projects. In 2012 The Treatment Alternatives and Diversion (TAD) partnership of the Office of Justice Assistance, DOC and DMHSAS which funds projects that provide alternatives to prosecution and incarceration for criminal offenders with substance abuse disorders expanded to nine county TAD projects. Also in 2012, Governor Scott Walker, in recognition of the importance of cross system communication and collaboration, mandated the creation of the state's first executive level Criminal Justice Coordinating Council. This council is tasked with planning initiatives and promoting policies that reduce recidivism, cut the future growth of correctional institutions, and improve coordination among all state agencies. The Department of Health Services (DHS) Secretary serves on this committee and DMHSAS is represented on the Problem Solving Court's subcommittee. The Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health continues to facilitate coordination with DOC, DHS, Division of Vocational Rehabilitation and the Social Security Administration by holding six meetings per year involving key personnel from each agency.

Institutional Services to Correctional Populations

Mental Health Institutions and Facilities
The DHS, DMHSAS operates the state's two mental health institutions. A 20 bed admission unit opened in the spring of 2013 to address a consistently high demand for forensic beds that included a 23% increase in 2012 in treat to competency defendants ordered by the court. In addition to the two state mental health institutes, the DHS, DMHSAS also operates three additional facilities:

- The Wisconsin Resource Center (WRC) is administered by DHS and DOC under s. 46.056, Wisconsin Statutes. WRC is a specialized mental health facility for persons whose mental health needs cannot be adequately addressed with the DOC prison setting. WRC has also been able to take individuals within the corrections system who were committed for competency restoration based on crimes occurring while in prison, who would have previously been in an institution bed. In 2011 a women's unit at the WRC was opened allowing services to be provided for females on a transitional basis as is the case for male inmates. The division's consultant on TIC was involved with the development plans of this facility.
- The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC serves the mental health needs of male adolescents transferred from Division of Juvenile Corrections institutions. Youth move to and from MJTC based on assessment of their mental health and security needs.
- Sand Ridge is a secure treatment facility in Mauston, WI, providing specialized treatment services for persons committed under Wisconsin's sexually violent person's law, Chapter 980, Wisconsin Statutes. This facility provides inpatient treatment in a secure setting and oversees the Supervised Release program whereby individuals committed under the law and are released by the courts, are placed in the community with intensive supervision and a full array of specialized treatment services.

Women's Prison Substance Abuse Treatment Program
DMHSAS administers a contract with DOC to co-fund a residential gender specific substance abuse treatment program at the Taycheedah Women's Correctional Institution. The cognitively based program includes assessment, substance abuse education, relapse prevention planning, problem solving/decision making skills, individual counseling, anger management, and abuse and victimization issues. Re-entry planning is also a part of services.

Juvenile Correctional Institution Substance Abuse Treatment Program
DMHSAS administers a contract with DOC to co-fund substance abuse treatment programs at the Lincoln Hills School for boys and the Copper Lake School for girls. During reception to the institution, all youth are screened for substance abuse needs with referral to treatment as indicated. The program covers a range of topics including, substance abuse education, self-awareness, personal inventory, communication, family/relationships, understanding feelings, decision making, relapse prevention, and abuse and victimization. Youth participate in group and meet with their treatment social workers individually. While in treatment they attend school and/or have jobs, participate in recreational activities and receive psychological and/or psychiatric services as needed. Continuing care plans are developed as youth transition back to the community.

Community Forensic Services

Conditional Release Program
The Conditional Release Program serves persons who have been adjudicated not guilty by reason of mental disease or defect and have been afforded the opportunity to transition into the community under judicial authority. When mental health professionals can make appropriate arrangements for an

individual to be released safely to the community, or who has been stabilized in the state institutes to be released under a Judge's authority to community supervision, the individual can regain some of the natural supports of community living and save the state costs of confinement. Through the Conditional Release Program, many are able to return to community living, securing supports and developing relationships with treatment providers before their commitment period expires. The Conditional Release Program has funded, coordinated, and administered quality forensic mental health services to 431 clients in FY 2012, with an average daily population of 284 clients. Community safety remains the programs first priority.

FY 2012's revocation rate was ten percent of the total population served (431) with a recidivism (new crime) rate of 0.2 percent. Over the course of the last 3 years, 81% of clients have been engaged in twenty or more hours weekly of meaningful activity, improving recovery outcomes and positive community reintegration. In 2012, 33% of participants achieved competitive employment, 76% were living independently, 100% were screened for Social Security benefits, and 82% achieved financial independence from the conditional release funding to be able to sustain their treatment, housing and medical needs by the time their legal commitment discharges. The program has engaged best practices and provided training to contracted case managers and probation/parole agents in person centered planning, trauma informed care and motivational interviewing and in 2013 will begin applying the stages of change principles and further expand the use of peer specialists.

Court Liaison Program
Court liaison services provide data tracking for forensic cases in the court system and assist in the timely movement of cases back to court resulting in reduced bed days at the mental health institutions. Through the development of a statewide tracking system and ongoing communication between the courts, forensic programs, mental health institutes and contracted providers problems are identified. Solutions are then developed to continue to effectively expedite movement of outpatient competency, competency to restoration and not guilty by reason of mental disease (NGI) cases. Training is also provided to the court staff on statutes and the related paperwork, processes and admission wait lists. Efforts over the last four years have provided 2373 bed days saved for the state.

Outpatient Competency Evaluation Program
The Outpatient Competency Evaluation Program began on January 1, 2002 with the anticipation that 75% of competency examinations could be done on an out-of-institution basis. The data indicates that since the program's inception, over 90% of the defendants have been able to be successfully examined in the community. The program continues to significantly exceed its goal and thus there was much less of a drain on the institutional resources and many more cases could be handled by the courts without the time delays associated with inpatient examinations. Moreover, fewer individuals had to undergo involuntary forensic inpatient commitments in order to resolve the competency questions and those that were adjudicated incompetent had access to treatment quicker. The fact that the courts and jails continue to give very favorable reviews reinforces the successfulness of the Outpatient Competency Evaluation Program.

Outpatient Competency Restoration Program
Beginning in 2008, the department was successful in having statutory language changed to allow for competency restoration of defendants charged with a criminal offense to be treated in the community. Still in a regional pilot stage, the program primarily works with defendants who have developmental disability needs, rather than acute psychiatric symptoms. In FY 12, 59 individuals were treated in the community. In addition to saving bed space at the mental health institutions, these individuals' lives were not unnecessarily disrupted by having to go inpatient. The same statutory language changes which were made in 2008 allowed the DHS to treat DOC inmates, who are facing charges but not competent to

proceed, in one of the state's Secured Treatment Facilities, the WRC. This voids the need to move inmates to a mental health institution. Seventeen inmates were restored in this manner in FY 12.

Opening Avenues to Reentry
This program is a partnership between the DHS and the DOC. Modeled after the DHS Conditional Release Program for mental health services delivery, it targets inmates who have been classified has having a serious and persistent mental illness and are considered to be a medium to high risk of reoffending. In its second year of operation, within a pilot comprising about one third of the state, the program served 142 participants, 111 of whom were placed in the community. This is an extremely high need population in virtually every domain. Individuals are provided an array of comprehensive, individualized, wrap-around services specific to their needs and risk factors both pre-release and in the community. The program employs a team approach involving institution treatment staff, contracted forensic case managers, community corrections agents, DHS program specialists, and community treatment providers. The program is showing solid results so far in reducing recidivism rates. Four percent of the population was convicted of new crimes during their enrollment in the program.

Substance Abuse Treatment Alternatives

Juvenile Justice Substance Abuse Treatment Initiatives
DMHSAS administers contracts to nine counties to screen youth who are referred from the court to juvenile court intake for reasons such as delinquency, truancy, and child protective services using the Problem Oriented Screening Instrument for Teenagers (POSIT) or the Positive Achievement Change Tool (PACT). Youth may be referred for prevention services or to a deferred prosecution agreement in which they agree to reduce or abstain from substance use and remain free from further justice system involvement. Youth may also participate in group/individuals sessions as a brief intervention often using the Teen Intervene and Celebrating Families models. Some counties have specialty courts like truancy or juvenile drug courts. Depending on the area of the state the juvenile justice staff may be involved with professional networks like the Milwaukee Co-Occurring Competency Cadre.

Juvenile Justice Gang Diversion
DMHSAS administers a contract with the Department of Justice (DOJ) to provide a youth gang diversion program in Milwaukee County. Through these funds staff from the Youth and Family Development Program (YFDP) speak with youth at elementary, middle, and high schools, sports leagues, and other youth serving organizations about the effects and consequences of tobacco, alcohol, and other drug use. YFDP is also a collaborator with Milwaukee County's Delinquency and Court Services Division through its collaboration with Milwaukee County Children's Court and Wraparound Milwaukee. Youth at risk and youth who are currently abusing substances are referred for assessment and linked to treatment and case management systems that serve as an alternative to incarceration.

Project Fresh Light
Project Fresh Light (PFL) began with money from a Substance Abuse Treatment Infrastructure grant. The purpose of this grant was to develop and improve state and local adolescent substance abuse treatment delivery systems. Through the efforts of PFL the following objectives continue to be met: 1) development of a resource directory of agencies providing adolescent specific services; 2) two published instructional manuals, the "Family Guide to Adolescent Substance Abuse Information and Services in Wisconsin" and the "Adolescent Framework and Practice Guidelines"; 3) the statewide distribution of the Global Appraisal of Individual Needs Short Screen (GAINSS), an evidenced based screening instrument, to all pupil services staff within Wisconsin schools; 4) the distribution of the Problem Oriented Screening Instruments for Teenagers (POSIT) to Juvenile Justice intake units; 5) sponsorship of the fourth annual conference, "Boys and Girls at Risk"; and 6) the establishment of the Child and Youth Substance Abuse

Treatment Subcommittee under the Intervention and Treatment Committee of the State Council on Alcohol and Other Drug Abuse.

Treatment Alternative Program
1988 Wisconsin Act 339 created the Treatment Alternative Program (TAP) program which currently funds programs in three counties. The program is designed to integrate the criminal justice and treatment systems by linking legal incentives with the therapeutic process using an intensive case management/treatment model. The program is a dispositional alternative to incarceration for the courts, as well as an alternative to revocation resource for DOC. Screening and assessment services are provided to help identify, assess and refer appropriate individuals into substance abuse treatment while monitoring their compliance with individually tailored goals for improved social functioning and reporting compliance to the referring criminal justice system component. The program provides an array of services in a wrap-around model to address risk factors associated with criminal behavior, address substance abuse and mental health treatment needs and improve an individual's overall social functioning. Cognitive behavioral, contingency management and motivational interviewing are some of the evidenced based approaches used based on the risk, need and responsivity principles. There is a strong emphasis on skill development that will increase the individual's success as a positively contributing member of society. TAP increases the accessibility of appropriate evidenced-based treatment for criminal justice clients and aims to reduce recidivism in county jails and state prisons through decreased incidence of substance abuse among the target population.

Problem Solving Courts
There are currently 57 problem solving courts in operation in Wisconsin through a variety of funding sources from the local, state and federal level. Among these courts are adult drug courts, Driving While Intoxicated (DWI) courts, hybrid DWI/drug courts, family dependency courts, juvenile drug courts, veterans courts, one mental health court, one tribal healing to wellness court and one co-occurring disorders court. Some counties with problem solving courts use money they receive through their share of the Federal Substance Abuse Block grant to fund treatment services for persons served by these programs. In 2011, the Wisconsin DHS and DOC began collaborating on the funding of two OWI courts pilot projects. This funding allows two counties to provide clinical coordination, medication assisted treatment, and alcohol and drug treatment to their court participants. In exchange for participating in OWI courts, participants serve fewer jail days on their current conviction in addition to the goal of lowering recidivism rates.

Enhancements to the Intoxicated Driver Program
The DHS, through enhancement grants for Intoxicated Driver programs, is utilizing the following strategies to reduce recidivism of impaired driving:

- Medication-assisted treatment which is effective in reducing cravings for alcohol allowing clients to focus on their treatment.
- Specific evidence-based treatment modalities shown to reduce recidivism.
- Biomarkers to monitor clients to determine abstinence while providing needed treatment services.
- Transdermal alcohol detection systems in lieu of mandatory jail time following conviction.

Treatment Alternatives and Diversion (TAD) Program
In 2005, Wisconsin Act 25 authorized grants to counties to establish and operate programs, including suspended and deferred prosecution programs and programs based on principles of restorative justice, that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs. As a result, collaboration among the Wisconsin Office of Justice Assistance (OJA), the Wisconsin DOC, and the Wisconsin DHS established the Treatment Alternatives and Diversion (TAD) grant program in 2006. The program began with the implementation of the program at seven sites with

expansion to an additional site in 2012. All TAD sites provide participants with case management, substance abuse treatment, drug testing and monitoring, but vary in program model/approach, length, treatment intensity, and target population. Four of the TAD sites are adult drug treatment courts and four sites utilize diversion models.

Prisoner Reintegration Program
In 1991, Wisconsin Act 39, authorized DMHSAS to fund services designed to assist persons who are Milwaukee County residents transition back to Milwaukee following their release from incarceration; thereby reducing recidivism. The program uses liaisons and mentors to meet with prospective program participants prior to their release to provide information and plan for release as well as services that address the longer term needs of reintegration into the community. Services aimed at the more practical and short term needs of persons releasing to the community address housing, access to daily necessities, transportation, child care, health care, employment, treatment referrals and emotional support. Long term services focus on interventions which address skill development, planning and linkage to services related to education, employment, housing, behavioral health needs, health care, trauma, family/relationships, parenting, social networks, cognitive skills and attitudes, and emotional functioning and problem solving.

Community Based AODA Services for Department of Corrections
DMHSAS administers a contract with DOC to provide funding for substance abuse treatment for adults and youth who are being supervised in the community by the DOC. Within the division of juvenile corrections, funds support continued treatment for youth who have transitioned back to the community from one of the juvenile institutions. Recent efforts have included training for treatment providers on the evidence based program models of Teen Intervene and Celebrating Families. A strong emphasis has also been placed on contracting with providers that include family within the treatment process. Within the adult community corrections division, DOC provides substance abuse halfway house services for Native Americans, women and males that are returning to the community from the institution or are under a formal alternative to revocation agreement due to substance use probation violations.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

Section IV: Narrative Plan

J. Parity Education

Although Wisconsin recently experienced a reduction in the amount of Mental Health Block Grant (MHBG) funding due to the redistribution of funds between states, the state will explore using Substance Abuse Block Grant (SABG) funds and MHBG-funded program development staff to create a communications plan to educate Wisconsin citizens and raise awareness about parity. The exact approach needs to be developed with key stakeholders.

The Wisconsin Department of Health Services (DHS) has had previous success in coordinating with entities across the public and private sector to address emerging issues that affect individuals with MH/SUD. It will endeavor to do the same with parity. In developing a communications plan, the state will pursue collaboration with organizations experienced in parity education, such as the New Day Coalition and Mental Health America of Wisconsin. In addition to mental health organizations, the state will explore partnering with substance-use focused entities, such as the Wisconsin Association of Alcohol and Drug Abuse Counselors, to help develop a plan.

In developing a plan, as outlined above, the state seeks to ensure that broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity. The work on this effort hasn't begun. First steps will be to conduct research on how the federal and state insurance and parity laws come together. Additionally it will be important in this process to assess the impact of parity laws on various types of private health insurance plans, and Medicaid programs and benefits. The Bureau of Prevention, Treatment and Recovery (BPTR) has assigned a staff person with a legal background to begin this research.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

Section IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Coordinated Care Initiative
The Wisconsin Department of Health Services (DHS) is pursuing several coordinated care initiatives. The HIV-AIDS Health Home was established in southeast WI under a 1945 State Plan Amendment (SPA).

DHS is also piloting several coordinated care initiatives under a 1937 SPA. The Foster Care Medical Home has been approved by Centers for Medicare & Medicaid Services (CMS) and is expected to be implemented by January 2014 as a pilot in six counties in southeast Wisconsin. It is a combined initiative with the Department of Children and Families, Division of Long Term Care, Birth to Three, and other entities. It will coordinate physical and other forms of care for approximately 2500 children in foster care in the region. DHS is also currently undertaking program design on a pilot for an integrated care model for consumers in fee-for-service Medicaid who have mental illness and one or more chronic physical conditions. This pilot is expected to be implemented in late 2013 or early 2014.

Addressing Nicotine Dependence in Behavioral Health and Substance Use Treatment System
Over the past decade Wisconsin has been gaining momentum in efforts to address nicotine dependence among individuals with mental health or substance use disorders. A key development in these efforts has been the formation of the Wisconsin Nicotine Treatment Integration Project (WiNTiP). WiNTiP has worked to integrate the treatment of nicotine dependence into the mental health and alcohol and other drug abuse health care system in Wisconsin for the past six years. The project is funded by the Wisconsin Tobacco Prevention and Control Program and the Division of Mental Health and Substance Abuse Services (DMHSAS). WiNTiP began in January, 2008 as a three year planning project coordinated by a steering committee of representatives from state representatives from AODA, mental health, tobacco, and the UW- Center for Tobacco Research and Intervention (UW-CTRI). The project works to train health-care providers working in the fields of addiction recovery and mental wellness to help patients recover from nicotine dependence. Part of the work also includes regional trainings across the state.

In 2012 WiNTiP introduced “Integration Innovator Awards” as a mechanism to recognize and encourage stakeholder organizations to take initial steps to integrate the treatment of tobacco dependence. The aim of this award program is to encourage and broaden the participation of clinicians, researchers, students, educators and consumers in the process of tobacco treatment integration.

In 2013 WiNTiP will award funding to two organizations to fully integrate the treatment of tobacco dependence into their clinical work. “Full Integration” has several required characteristics. First, every patient accepted for treatment must have tobacco use assessed and all with tobacco dependence must receive evidenced-based treatment appropriate for the patient’s motivation. Tobacco dependence and its treatment will be tracked just as any other diagnosis and treatment (represented in problem lists, incorporated in treatment plans, measured as an important outcome, etc.). Second, to the degree that an organization has policies regarding the use of other addicting, harmful substances, those same policies will address tobacco use. Third, organizations will be tobacco free campus wide for all patients, staff and visitors. This includes the use of tobacco product in private cars while on the grounds and the use of tobacco products in vehicles when used for business purposes. For organizations that have multiple locations representing a continuum of care, each must be tobacco free. This would include tobacco free residences when lodging is provided as part of treatment (UW-CTRI, 2013). Through the continued support of the WiNTiP Wisconsin can continue to provide nicotine dependence treatment and prevention among individuals with mental health or other substance use disorders.

In addition to the WiNTiP efforts described above, tobacco use is regularly screened for in Wisconsin's Comprehensive Community Services (CCS), and Community Support Programs (CSP).

Screening and Referring
Presently data collection is rather limited for behavioral health providers to monitor medical conditions. Within administrative rule for the Community Support Programs (CSP under DHS-63) and Comprehensive Community Support (CCS under DHS-36), there are standards to ensure that physical health is assessed along with a variety of other dimensions of life. It is part of the responsibility of the program to assure that medical care is rendered. Annually, the CSPs and CCSs are surveyed for the numbers of participants who have the following conditions over the course of the prior year:

- Metabolic Syndrome
- Hypertension or High Blood Pressure (excluding those with metabolic syndrome)
- High Cholesterol (excluding those with metabolic syndrome)
- Obesity (excluding those with metabolic syndrome)
- Diabetes (Type I or Type II)
- Asthma
- COPD (Chronic Obstructive Pulmonary Disease)
- Cardiovascular Problems (generally defined)

Additionally the survey is designed to collect information regarding the number of consumers who use tobacco, and/or abuse alcohol or other drugs.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

Section IV: Narrative Plan

L. Health Disparities

Every two years, Wisconsin produces the *Wisconsin Epidemiological Profile on Alcohol and Other Drug Use*. The most recent publication was completed in September 2012 and will be repeated in September 2014. This report collects data for alcohol and drug consumption rates, consequence rates and individual and community risk factors. To the extent possible, the report identifies individuals by race, ethnicity, age and gender. This report is primarily used to identify priorities and populations at greater need for substance abuse prevention services. Where available, the data is also collected on a county by county basis.

The Department of Health Services also completed a Mental Health and Substance Abuse Needs Assessment (Appendix 1). This needs assessment is defined as a "data-driven and systematic exploration and determination of the gaps between the current conditions and desired conditions." The goal of the needs assessment is to develop a set of state-specific, data-driven and realistic priorities, objectives and strategies to address identified needs and gaps. The objectives selected must have measurable performance indicators associated with them and the measures must be tracked. Selected indicators from four broad categories of data and information will be collected and analyzed as part of this needs assessment. The indicators were selected based upon data availability and having been previously identified as a priority problem or need through Wisconsin surveys, studies, or stakeholder or public input.

The four broad data collection areas include:

Populations(s) Affected: This refers to the prevalence of disorders, conditions and associated problems for the entire population as well as for special populations such as the homeless, females, cultural groups, youth, older adults, veterans, rural populations and criminal justice offenders. This analysis will answer the questions, what are the problems, what is the extent of the problems and what is the need for services, strategies, supports or treatment across different populations?

Access to Services, Strategies, Supports and Treatment: This analysis will answer the questions: Are populations able to gain entry to services, supports or treatment? Are prevention strategies in place in communities? Do people receive preventative, treatment or support services when (timeliness) and where (geographically available) they need it? What are the barriers to receiving services and strategies? What proportion of the population are recipients of services, strategies, supports and treatment (treated prevalence or penetration rate)?

Availability and Capacity of Services and Strategies: What types of services and strategies are needed and what is the capacity of the system (including number of providers and workforce characteristics) to meet the needs? What is the capacity of the system to produce a culturally and linguistically appropriate mix of services to meet the needs of the populations affected? Are the resources in the system appropriately aligned and cost-effective (i.e. relative use of more intensive inpatient care compared to other community based care)?

The Quality, outcomes and Impact (effectiveness) of Services, Strategies, Supports or Treatment: Do people receive "appropriate" preventative, treatment or supportive services? Are the services, strategies, supports or treatment of desired quality? Are the services or strategies safe, client-centered, efficient, equitable, evidence-based, effective or otherwise proven to work? What happened to the consumer and/or the system as a result of the interventions, strategies, services or supports? What is the impact? What is and is not achieved to ameliorate the condition, disorder or problem? Outcomes to be measured will also

include what consumers believe are important to them as well as those outcomes important for the overall system.

A formal, combined mental health and substance abuse needs assessment committee consisting of members of the Governor-appointed Wisconsin Council on Mental Health and State Council on Alcohol and Other Drug Abuse (SCAODA) was established to provide guidance and direction about issues to examine, to review the analyzed data, provide a preliminary ranking of priorities, and assist with developing strategies and performance indicators. A tool based on a public health program priority rating model was developed to rate and rank the gaps, issues and problems identified through the Wisconsin needs assessment.

Public and stakeholder input was sought through a brief 3-question survey asking about mental health and substance abuse needs, service gaps, problems and issues. Consumers, advocacy groups, service providers, Tribal agencies, veterans and county intermediary agencies submitted completed surveys.

The assembled data and information in this report come from a variety of primary and secondary data sources including U.S Census Bureau, National Survey on Drug Use and Health, Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System, CDC's Youth Risk behavior Surveillance System, Wisconsin Mental Health Statistics Improvement Program survey, Wisconsin County Public Treatment Form, Wisconsin Human Services Reporting System, Wisconsin Medicaid Claims database, Wisconsin Crime Information Bureau, Wisconsin Public Health Profiles, Wisconsin Mortality Records database, Wisconsin Traffic Crash database and others.

Services are tracked through two systems including the Human Services Reporting System (HSRS) and the Substance Abuse Prevention - Services Information System (SAP-SIS). Both systems collect information on type of prevention/treatment service by age, race and ethnicity.

The language needs of populations living within Wisconsin primarily fall within two groups, Hispanic and Asian. Substance Abuse Prevention and Treatment funds are provided to county Human Service Agencies. County agencies are responsible for assuring that translation services are available when needed. In addition, the SCAODA has also adopted the National Standards on Culturally and Linguistically Appropriate Services (CLAS).

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Section IV: Narrative Plan

M. Recovery

Indicators/Measures

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, Wisconsin embarked on supporting and promoting the concept of recovery in 1997 with the state's Blue Ribbon Commission. Born of this commission, was the statewide Recovery Implementation Task Force (RITF). The RITF, comprised primarily of consumers, advises the Bureau of Prevention, Treatment and Recovery (BPTR) on policy-making and issues affecting citizens with mental health and substance use disorders. The mission of the task force is to "transform Wisconsin's mental health and substance abuse services to embody recovery, hope, dignity and empowerment throughout the lifespan, in partnership with the Department of Health Services (DHS), the Division of Mental Health and Substance Abuse Services (DMHSAS), and the BPTR." Wisconsin has engaged stakeholders to fully vet a definition of recovery, at which time the SAMHSA definition was officially adopted. Given that SAMHSA has changed this definition as well as the ten fundamentals since this date, Wisconsin intends to solicit consumer, and other key stakeholder input, to revise the definition of recovery and recovery values.

In 2012 Wisconsin completed a similar process to develop a definition of peer support. A stakeholder meeting was convened in a central location, with invitees from key stakeholder groups throughout the state from both substance use and mental health disorder interest groups, including a high percentage people in recovery. A survey was developed and distributed statewide to gather information. Follow up communication via e-mail, public website forum, and teleconference was utilized to solicit further input from a broader group. Wisconsin envisions utilizing a similar model to create a new or revised definition for recovery.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Yes, Wisconsin has three leadership roles held by individuals in recovery. Within its BPTR, Wisconsin employs a Consumer Affairs Coordinator, a person with lived experience, who has a key role in policy-making and outreach to consumer stakeholders to elicit and increase meaningful participation. In addition, the Coordinator is a key staff to the two Governor appointed state councils; the Wisconsin Council on Mental Health (WCMH) and the State Council on Alcohol and Other Drug Abuse (SCAODA). A new role for this position is that of contract administrator for the Statewide Consumer and Peer Support and Leadership Development grants, which provide financial support and technical assistance to eleven consumer operated recovery centers and the development of consumer leadership.

The second recovery focused position is that of State Certified Peer Specialist Coordinator, who is also a person with lived experience. This position serves as a central point of contact with regard to all of the State's Certified Peer Specialist initiatives. The third position is the statewide program coordinator for the Alliance for Recovery Advocates and is also a person with lived experience from substance use disorder.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes, Wisconsin has also embraced the use of person-centered planning and has promoted its use through the provision of training and technical assistance to a variety of county and public mental health providers and consumers. Through the BPTR, Wisconsin has a team focused on the training and provision of Person-Centered Planning. In addition, Wisconsin has, through State Plan Amendment 1915i, a Community Recovery Services (CRS) program with three benefits focused on rehabilitation and consumer empowerment. Wisconsin has established Person Centered Planning training and implementation as a requirement of all CRS counties.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes, Wisconsin has utilized the Mental Health Block Grant (MHBG) to support eleven consumer operated recovery centers which deliver a variety of peer support, including a warm line, consumer/family education, and peer specialists. In addition, Wisconsin has created a Certification for Peer Specialist (CPS) services, that when provided within psycho-social rehabilitation programs, are reimbursable by Medicaid. In addition to these programs, Wisconsin has promoted the use of CPSs and peer support within crisis services. Each county in Wisconsin is responsible for the provision of crisis services and have the ability to also provide and receive reimbursement for the provision of Crisis Stabilization Services that can be provided in a community based rehabilitation facility or individually based community services. Counties are able to employ and utilize CPSs in the provision of either crisis service. Wisconsin has supported training for Recovery Coaching to be used in the provision of substance use disorder treatment. At this time, Wisconsin is working to define core competencies for recovery coaches and explore implementation in community services and potential for reimbursement. Currently, Wisconsin has legislative and budget authority to develop Peer Run Respite services. Wisconsin has funded and supported the adoption of Individual Placement and Services model of supported employment. Wisconsin received a grant from the Johnson & Johnson / Dartmouth Learning Collaborative and currently has six Individual Placement and Support sites, including a four county rural consortium.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Yes, as of January 2013, Wisconsin has 294 CPSs. CPSs are employed in a variety of settings that do provide services to special populations. However, the state does not have a mechanism to track the number of CPSs providing services to special populations. Wisconsin has, however, engaged stakeholders to develop a training and certification process for Parent Peer Specialists. Wisconsin does have a vision to continue to explore the needs of special populations within its Peer Specialist Certification.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes, Wisconsin provides or supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. Wisconsin had a position, housed in BPTR, of Recovery Coordinator. This position was charged with, in conjunction with the RITF and other stakeholders to develop the State vision of recovery. This included the training for professional workforce and support of the inclusion of recovery principles in the provision of mental health and substance use disorder services. The Recovery Coordinator partnered with trained consumers to present Recovery Concepts in Practice training. Wisconsin has required this training as a pre-requisite to providing CRS services. In addition, the CPS Program coordinator provided training and technical assistance to employers regarding the role of CPSs in the workforce. The Recovery Coordinator had developed an Employer Guidebook and was tasked with developing an employer advisory group and the development of four Employer Training and Technical Assistance pilots with county providers. Recovery principles have also been disseminated during several annual mental health and substance abuse services and crisis services statewide training conference. Additionally, the statewide RITF has recently decided to refocus its work on the dissemination of recovery principles and developed a Recovery Education Committee to address these topics.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes, Wisconsin does have an exam process for CPSs. Wisconsin in 2013 directly contracts with eleven peer-run recovery centers in 2013. These centers were previously were contracted utilized a fiscal agent in a sub-grantee agreement. The State Consumer Affair Coordinator works with each of the centers to collaborate and develop standards for block grant funded consumer-operated recovery centers. Recommendations for benchmarks and a peer review system are expected to be finalized within the next two years.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

The RITF of Wisconsin is our exemplary activity that goes beyond block grant requirements. Wisconsin embarked on supporting and promoting the concept of recovery in 1997 with the state's Blue Ribbon Commission. Born of this commission, the statewide RITF has worked continuously since 1997. The task force is comprised of consumers, advocates, providers and state staff who have significantly impacted the policy of DHS. RITF's mission is to "transform Wisconsin's mental health and substance abuse services to embody recovery, hope, dignity and empowerment throughout the lifespan, in partnership with DHS, DMHSAS, and the BPTR."

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

Wisconsin incorporates individuals with lived experience and family members on State Councils, Task Forces and state policy initiatives. This participation also occurs at the county and local level as counties also include this participation in the planning, delivery and evaluation process of mental health and substance abuse services. The Wisconsin Statewide Consumer Network recently developed a statement on meaningful consumer participation in policy making. The WCMH has worked to assist the network to promote this statement within all of the pertinent state departments. Wisconsin has been striving towards implementing these principles by including consumers and families from the inception of the policy planning process. To facilitate this inclusion, the DMHSAS has created a webpage to post opportunities for consumer and family involvement. In addition, consumers are trained and prepared to fully participate in the creation of their recovery plans and service provision through the state supported Person Centered Planning.

Another means by which individuals in recovery are involved is through Peer Specialists that are trained and certified in Wisconsin. CPSs work with people in recovery to foster self-advocacy and assist individuals to fully participate in services. The Individualized Placement Services (IPS) supported employment project works closely with the statewide National Alliance on Mental Illness (NAMI) to educate families about IPS, support IPS sites and to participate in IPS fidelity reviews. People with lived experience also participate in fidelity reviews. Finally, at the state, county, and local levels, consumers and family members are surveyed with regard to the provision of mental health and substance abuse services.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

Yes, Wisconsin has partnered with our statewide consumer organization via listening sessions and a consumer conference. Monthly teleconferences/webinars will be scheduled with the Consumer Affairs Coordinator. The Alliance for Recovery Advocates holds listening sessions throughout the state on issues related substance use disorder. During the yearly mental health and substance abuse training conference, a consumer listening session is held with key policy-makers, and concerns are followed up by administration.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Wisconsin’s initiative with person-centered planning for consumers provides opportunities for individuals to proactively engage in the behavioral health service delivery system. Many behavioral health providers engage families in Family psycho-education and consumers in Wellness Recovery Action Plans. Wisconsin also provides funding for NAMI to train and work directly with individuals and family members in Peer to Peer and Family to Family programs. The use of CPSs in many aspects of the behavioral health field also offers important opportunities for service participants to be supported in directing their ongoing care.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Wisconsin has supported for the past year a Parent Peer Specialist workgroup that is nearing completion of recommendation for certification of Family Peer Specialist. Wisconsin supports the NAMI, which provides support networks and self-help programs to consumers through multiple local chapters statewide. Recovery organizations are supported through block grant funds to consumer operated recovery centers.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Wisconsin statutes do address housing needs of persons served so that they are not served in settings more restrictive than necessary. Congruent with Olmstead, Wisconsin statutes under the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act (Chapter 51) and Protective Placement (Chapter 55) both require treatment in the least restrictive setting. Moreover under the Patient Rights and Resolution of Client Grievances (DHS-94) there is a least restrictive treatment requirement, with some limited caveats, "each patient shall be provided the least restrictive treatment and conditions which allow the maximum amount of personal and physical freedom…."

Several of Wisconsin's county operated or contracted community mental health programs require attention to the housing needs of their consumers. In the DHS program, Community Support Program (CSP, DHS-63), part of the criteria for admission for those with a serious and persistent mental illness is the consequent risk of institutionalization or living in a severely dysfunctional way. And one of the functional criteria for admission includes basic adult functioning in the community including care of one's residence and ability to procure housing.

Within the Emergency Mental Health Services rule (*Crisis*, DHS-34), services are made available in the community to address crisis situations where the person lives, works, or recreates. Through 24-hour phone services, walk-in services, and mobile outreach services individuals who are in a mental health crisis or who are at high risk of a mental health crisis are provided assistance such that the person's immediate distress can be eliminated or deescalated while helping the person return to a safe and more stable level of functioning. Optional stabilization resources are available in many of these county-based programs to provide short term, intensive, community based services to avoid the need for inpatient hospitalization or shorten an inpatient length of stay.

Within the DHS program Comprehensive Community Services program (CCS, DHS-36), homeless or at-risk for homeless meets the high-intensity service need. Moreover, one of the CCS assessment domains includes basic needs and housing needs. Similarly, the Community Recovery Services (CRS, 1915i benefit) has as a required assessment domain, housing needs.

For those who are homeless, Wisconsin is working with the SSI/SSDI Outreach, Access and Recovery (SOAR) model to help many homeless and disenfranchised individuals obtain urgently needed disability benefits and related insurance, enabling the person to have a life off of the street. Disability benefits help pay the rent; whereas medical insurance enables access to medical and behavioral health treatment. Considering the loss of the Homeless Specialist requirement for the Social Security offices, SOAR has an even more important role. SOAR funding is presently administered through the Department of

Administration (DOA), Division of Housing. Through an Interagency Agreement between DHS and the DOA funding is supplied through DHS to support the SOAR initiative.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

Section IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Primary Prevention Services Needed

The Wisconsin Department of Health Services (DHS) remains strongly committed to moving towards need-based funding of services through improved data collection and analysis. One important aspect of prevention services is the ability to track the needs of communities through epidemiological factors. Based on identified needs, resources can be allocated to address the problem using evidence-based programming. To support this ongoing effort, the DHS produces a State Epidemiological Profile every two years. The State Epidemiological Profile presents the most currently available data on consequences of use, consumption patterns and community and individual risk factors related to substance use, misuse and abuse. This assessment is used to identify substance abuse prevention priority issues in the state. The 2012 Report identifies five prevention priorities for the state:

1. Underage drinking (ages 12-20)
2. Adult binge drinking (ages 18-34)
3. Drinking among pregnant women
4. Alcohol-related motor vehicle fatalities and injuries (especially among people ages 16-34)
5. Drug-related deaths (with a focus on unintentional opioid-related overdoses and deaths among people ages 20-54).

Primary Prevention Programs and Methods

The State of Wisconsin provides Substance Abuse Block Grant (SABG) funding to all 72 counties and 11 Tribes through a formula allocation. Each agency that receives SABG funds is required to spend 20% on primary prevention services. In 2007 the State implemented an online reporting system for collecting National Outcome Measures (NOM) data from county and tribal providers on the SABG prevention set-aside. Since that time, agencies have used the Substance Abuse Prevention Services Information System (SAP-SIS) to report NOMs data related to the local implementation of prevention programs. The State monitors this reporting through yearly reviews. The yearly SAP-SIS system reviews are used to improve the quality of prevention services being provided. Ongoing training and technical assistance is provided to new staff in the use of this system and in appropriate uses for the prevention set-aside. Based on these reviews, the State began requiring all counties to select evidence-based prevention strategies from either a national registry of evidence-based substance abuse programs or from two state recommendation reports that have been produced by the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA). The state will require that all prevention activities are in-line with the five state priorities identified in the 2012 State Epidemiological Profile, are evidence-based, and meet the needs of the local community.

In addition, the state provides support to local substance abuse prevention coalitions through five prevention regional centers that are tasked with providing training and technical assistance to substance abuse prevention coalitions in their region. Through this structure, the state funds an annual statewide "Parents Who Host Lose the Most: don't be a party to underage drinking" media campaign.

Prevention System and Workforce Capacity Building

Wisconsin DHS provides funds to the Wisconsin Clearinghouse for Prevention Resources for the development, and provision of an annual statewide Prevention Conference. This conference brings together prevention professionals from around the state to share ideas, gain knowledge related to

substance abuse prevention and network with other providers. By attending this conference, attendees receive Continuing Education Units towards their Prevention Specialist certification.

In addition, DHS is working with the Center for the Application of Prevention Technologies (CAPT) to provide Substance Abuse Prevention Specialist Training (SAPST) – Training-of-Trainers in 2013. This opportunity will allow 15 prevention professionals to be certified in delivering SAPST curricula to other prevention professionals around the state. DHS will hold two SAPST trainings per year in order to train the prevention workforce and certify providers as Prevention Specialists.

Through the Alliance for Wisconsin Youth (AWY), Regional Prevention Centers ongoing training and technical assistance to local substance abuse prevention coalitions is provided related to the Strategic Prevention Framework, emerging drug trends, evidence-based programs and policy initiatives.

DHS will continue to provide training to county and tribal prevention providers in the use of the online data reporting system (SAP-SIS), including appropriate uses for SABG funding, the Strategic Prevention Framework, the continuum of care, IOM strategies and partnering with local community coalitions to achieve outcomes related to the State's five prevention priorities.

Prevention Strategy Outcome Data Collection

The Wisconsin DHS collects outcome data through national reports such as The National Survey on Drug Use and Health (NSDUH), The Behavioral Risk Factor Surveillance System (BRFSS), and The National Highway Traffic Safety Administration (NHTSA) as well as state reports such as Youth Risk Behavior Surveillance System (YRBS). These findings are reported every two years in the State Epidemiological Profile. The profile tracks trend data in substance abuse and provides the state the ability to identify needs for ongoing services.

In the past few years, Wisconsin has seen a decline in underage drinking and underage binge drinking, however adult drinking and binge drinking continues to be high. In addition, Wisconsin has a high rate of pregnant women reporting that they drink during pregnancy, as well as increasing overdose deaths related to opioid abuse. Through the Epidemiological Profile, DHS will continue to monitor these trends in order to identify evidence-based prevention strategies to reduce substance use, misuse, and abuse and mitigate the associated harmful consequences.

Strategic Prevention Framework

Wisconsin DHS has institutionalized the Strategic Prevention Framework by:

- Producing a State Epidemiological Profile every two years to identify statewide priorities around substance abuse (Assessment);
- Providing SAPST training, an annual prevention conference and Prevention Regional Center support to local coalitions (Capacity building);
- Supporting and staffing the SCAODA and its sub-committees in the development of a four-year strategic plan and budget initiatives (Strategic Planning);
- Funding counties, tribes and community groups to provide prevention services (Implementation); and
- Monitoring the use of prevention funds through the Substance Abuse Prevention Services Information System (SAP-SIS) for programmatic quality improvement purposes (Evaluation).

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

Section IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG

The Division of Mental Health and Substance Abuse Services (DMHSAS) annually allocates up to $2,513,400 to counties through community aids formula allocations. The purpose of these funds is to expand the county-operated or contracted system of community-based services for adults with Serious Mental Illness (SMI) and children with Severe Emotional Disorder (SED). These funds must be used to initiate new programs, or significantly strengthen existing programs. DMHSAS promotes and supports the use of evidence-based practices (EBP) as part of these county allocations. The 2014 Wisconsin State Mental Health Plan identifies and describes a number of programs that help meet the needs of both adults with SMI and children with SED. The Community Aids Formula Allocation funds are to be used to expand a number of these services; specifically, the funds allocated to county programs may be used for the following program priority areas: wraparound program development and service delivery, supported housing program development and service delivery, initiatives to divert persons from jails to mental health services, development and expansion of mobile crisis intervention programs, consumer peer support and self-help activities, Community Support Programs or Comprehensive Community Services, psychosocial rehabilitation services , development of strategies and services for persons with co-occurring mental health and substance abuse disorders, and mental health outcome data system improvement. Though DMHSAS requests information on the use of evidence based practices from counties, DMHSAS does not currently have a program to monitor the fidelity of the use of EBPs. DMHSAS is in the process of expanding the use, monitoring the use of, and monitoring the fidelity of EBPs.

Community Support Programs (CSP) are an example of a program that supports EBPs. These programs are encouraged to provide EBPs to the people they serve. Fifty-nine of the 72 reporting CSP programs (82%) reported using at least one EBP in 2011. The remaining 13 program (18%) reported using no EBPs in 2011. Lafayette County, Eau Claire County, Milwaukee County Department of Health and Human Services, and Dane County's Program of Assertive Community Treatment reporting using the most EBPs assessed in the survey: six each. In 2011, over 60% of programs were measured to be to the highest fidelity with Assertive Community Treatment (ACT). Additional EBPs utilized by CSP programs in the State include Integrated Dual Disorder Treatment, Illness Management and Recovery, Supported Employment, and Medication Management, and Family Psychoeducation.

In 2011 the following was spent by county grantees via the community aids allocation on the following services and programs for which the use of evidence based practices are promoted.

Community Support Programs(CSP)	$1,195,463.00
Supported Housing	$137,399.42
Jail Diversion	$28,320.91
Crisis Intervention	$492,905.00
Family, Consumer, Peer Support	$51,114.00
Children/Adolescent (SED)	$452,038.26
Dual Diagnosis Adults	$61,765.41
Comprehensive Community Services (CCS)	$71,899.00

Coordinated Services Teams (CST) are MHBG funded wraparound programs in Wisconsin which promote and support the use of evidence based prevention and treatment approaches. CSTs utilize a wraparound process to respond to individuals and families with multiple and often serious needs in the least restrictive setting possible. This wraparound process is based on family and community values, is

unconditional in its commitment to creatively address needs, and supports community-based options. Each child and family-centered team develops an individualized plan, incorporating the strengths of the child, family, and team members to work toward identified goals. Parents / care givers are equal partners and have ultimate ownership of their Plan of Care. The initiative is founded on many evidence based core values including being family-centered, consumer involvement, building on natural and community supports, community creativity and flexibility, strengths-based planning, unconditional care, embracing collaboration and a team approach, gender/age/culturally responsive treatment, self-sufficiency, a focus of education and work, outcome-based, and an overall belief in growth, learning, and resilience.

Other examples of the use of EBPs include the funding of peer support services, including peer run recovery centers, peer leadership development, and certified peer specialists. Block grant funding is also utilized for supported employment programs. The DMHSAS is committed to the use of EBPs and will continue to emphasize their use and fidelity.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

Section IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

System of Care Approach

Wisconsin has been developing collaborative systems of care since the early 1980s, when grants were received from the National Institute of Mental Health and the Robert Wood Johnson Foundation. In 1989 Wisconsin' Children Come First Act (State Statute 46.56) was enacted.

This statute authorized the creation of Integrated Services Projects (ISP) and described a framework for their development and operations. In that legislation the wraparound process was described as "based on family and community values, is unconditional in its commitment to creatively addressing needs and supportive community based options."

In 2009, the ISP legislation was revised through Act 334. Some updates were made to the legislation including expansion of the target population to children who are being served by two or more service systems, permitting children and youth with substance use disorders access to the team process. In addition, the name of the initiative was changed to the Coordinated Services Team (CST) Initiative. The legislation continues to require that the Department of Health Services (DHS) provide funding for this initiative (grants and technical assistance/ training). Funding is from several different revenue sources including the mental health block grant (MHBG). The Governor's recent budget proposal (FY 2014-2015) included a significant investment in the CST initiative to expand the program statewide. The legislature recently approved the additional funds, and the Governor signed off on the Budget on June 30, 2013. The Bureau of Prevention Treatment and Recovery (BPTR), in collaboration with the Children Come First Advisory Council (mandated by the CST legislation), is in the process of evaluating the existing CST program and developing a plan for the next generation of CSTs.

Lastly, staff of the Children Youth and Families Unit of the BPTR monitor and administer the grants. The new budget includes a FTE position related to the CST expansion. The position description for that person is currently being prepared—it is expected that person will, among other tasks, be responsible for reviewing the Unit's current monitoring and oversight practices and making recommendations to improve them. In addition, greater attention will be given by this position, to fidelity of the initiative.

Individualized Care Guidelines and Planning

Wisconsin has guidelines for individualized care planning. Wisconsin builds plans of care for children and youth based on information obtained from the Assessment Survey of Strengths and Needs—CANS Comprehensive. The team and the family are involved in discussing each child's strengths and needs and prioritizing them. Once the top three needs have been agreed upon the development of the care plan begins with the identification of a long term goal. Once a long-term goal is chosen, the team determines short-term goals, objectives, and tasks, and identifies who will be doing what, by when and how it will be paid for. Plans of Care must be updated every six months. In addition, Crisis Response Plans for each child/youth are also required.

Collaboration with other Child- and Youth- Serving Agencies

Wisconsin is fortunate to have a culture of inclusion and collaboration and is very successful in establishing and maintaining collaborative relationships with other state agencies that serve children and youth, the private sector, consumers, and family members.

Staff from the Children Youth and Families Unit are involved in collaborative activities that involve stakeholders from a number of service agencies, and have parent representation. Some examples follow:

- Staffing of the Children and Youth Committee of the Wisconsin Council on Mental Health. This committee meets monthly and the membership adheres to the requirements for the Community Mental Health Services Block Grant Planning Council.
- Staffing of the Children Come First Advisory Council to the CST's. This committee meets quarterly. Membership is mandated by State Statute and includes parents of children, child welfare, juvenile justice, public schools, higher education, private providers, and vocational rehabilitation.
- The Children Youth and Families Unit has a full time staff member who spends all her time helping agencies implement a Trauma Informed Care environment. While this effort is across the life span, she has worked with a number of child serving programs. In addition she collaborates with the Department of Public Instruction in their Trauma Sensitive Schools Initiative, and with a number of stakeholders in the Wisconsin Adverse Childhood Experiences Initiative.
- The Transformation Transfer Initiative is an activity funded by SAMHSA that involves DHS, the Department of Corrections Juvenile Justice Division and the Statewide Parent Advocacy agency, Wisconsin Family Ties. The initiative is developing a trauma informed care environment in one cottage at the juvenile corrections facility.
- Staff from the Unit participate in the Parent Peer Specialist Planning group that is developing guidelines for both mental health and substance abuse Parent Peer Specialists and a certification process. This group meets monthly and includes numerous representatives from the mental health and substance abuse communities. On July 10th, 2013 this group made its recommendations to the Division of Mental Health and Substance Abuse Services leadership on the process to certify Parent Peer Specialists.

Training in Evidence Based Practices

The Bureau recently hired a new staff member who will direct the Unit's efforts on Evidence Based Practices. This effort is closely tied to Wisconsin's collaboration between Medicaid, the mental health agency and child welfare, that is exploring the increased use of psychotropic medications by children and adolescents, and planning to reduce that use, by offering clinicians' evidence based interventions and treatments.

In addition, the Unit has a vacant position for an Adolescent Treatment Coordinator specializing in substance use and co-occurring disorder. A position description has been prepared and the hiring process will commence soon. The person previously in this position was very effective in disseminating information on several Evidence Based Practices (EBP's) for adolescents; this position will continue those efforts.

Monitoring and Tracking Service Utilization, Costs and Outcomes

The monitoring and tracking of service utilization, costs and outcomes for children and youth served under the CST initiative is a shared responsibility between the State and the legislatively mandated State Advisory Council. The legislation states: "This committee shall establish principles and core values for administering the initiatives, monitor the development of the initiatives throughout the state, and support communication and mutual assistance among operating initiatives as well as those that are being developed."

In addition, the legislation requires that the DHS evaluate the initiative addressing the following:

1. The number of days that children enrolled in the initiative spent in out-of home placement compared to other children who are involved in two or more systems of care and are not enrolled in the initiative and the costs associated with these placements.
2. A comparison between any changes in problem behaviors of enrollees before and after enrollment in the initiative.
3. A comparison between school attendance and performance of enrollees before and after enrollment in the initiative.
4. A comparison between recidivism rates of enrollees who have a history of delinquency.
5. Parent and child satisfaction with the initiative.
6. Types of services provided to children and their families through the initiative and the cost of these services.
7. A systems change plan and sustainability plan.

This evaluation is conducted every year by BPTR evaluators and the results are included in a CST Annual Report. The analysis of this data is a crucial component of oversight/monitoring activities. Counties have been very successful in demonstrating the use of CSTs as a means to reduce costs. The Advisory Council has been discussing ways to better demonstrate cost efficiency, effectiveness and positive outcomes and, as previously indicated, the BPTR will also be working on improving its oversight activities.

The State has not identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services. This would be very difficult to implement in Wisconsin as the 72 Counties and 11 Tribes are very independent.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

Section IV: Narrative Plan

P. Consultation with Tribes

The Wisconsin Department of Health Services (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) maintains business relationships with the eleven Tribal Nations located in the State and with the Great Lakes Inter-Tribal Council which is a membership organization designed and administered by the Tribes. Currently each Tribal Nation receives a portion of mental health and substance abuse block grant funding as well as state level funding targeted to particular program areas or services. In preparation for the combined mental health and substance abuse block grant application for fiscal year 2014, DMHSAS engaged the Tribes in consultation on the mental health and substance abuse block grants. The following information describes the consultation process.

DHS maintains a formal consultation process with the Tribes. This effort is endorsed by the Governor and Tribal Leadership. On two occasions each year state agency leadership meets with Tribal leaders to discuss relationship issues and business initiatives. In 2012 the DHS Secretary's Office held consultation meetings with Tribal Nations on May 23 and November 15. At both of meetings representatives from DMHSAS presented information on the mental health and substance abuse block grants and the needs assessment related to the block grant review. Tribal leaders were asked to assure Tribal representation in events scheduled specifically for the Tribes about the block grants.

On July 26 and August 9, 2012 DHS-DMHSAS hosted meetings for Tribal Nations on the block grants. The July 26 meeting focused on an orientation to the block grants, how the funding is currently used in Wisconsin, and the amount of block grant funding allocated to Tribal programs. The August 9 meeting focused on the block grant needs assessment. Each Tribe was asked to identify recommendations for mental health and substance abuse services based on the unique needs of tribal populations. Nine of the eleven tribes in Wisconsin participated in these events.

On February 28, 2013 DHS-DMHSAS engaged the Tribes in a review of block grant priorities identified through the needs assessment. Tribes participated in an effort to assign priority levels to the needs and issues identified. They also presented their support for future use of block grant funding consistent with the interests of tribal members.

In addition to the events specifically focused on the block grants, DHS-DMHSAS engages the Tribes in regional meetings related to mental health and substance abuse programming through DHS' Area Administration staff. These forums engage Tribes and county providers to address issues of mutual concern. Programs funded by the block grants are often a subject of discussion at these events.

The Division also participates as a co-sponsor with the Tribal Nations of a group called the Tribal State Collaborative for Positive Change. This group meets regularly to focus on mental health and substance abuse needs and programs of tribal members. A key focus for the past few years has been on the promotion of integrated treatment for substance abuse and mental health in the tribal delivery system.

Tribal Nations were active participants in DHS-DMHSAS efforts to develop a representative needs assessment product for the block grants. Tribes in Wisconsin have many unique needs; they have difficulty recruiting and maintaining providers of service, in particular providers that are considered culturally competent. Wisconsin is also experiencing an increase in prescription drug abuse among adults and children that is having a significant impact on Tribal Nations. DHS-DMHSAS is addressing these and other areas through block grant planning activities.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Section IV: Narrative Plan

Q. Data and Information Technology

Information Technology Systems

Wisconsin has three client-level data reporting systems for different groups of mental health and substance abuse consumers. The primary system for counties to record data describing all clients served in the public mental health and substance abuse data system is called the Human Services Reporting System (HSRS). The HSRS is administered by the State Mental Health and Substance Abuse Authority - the Division of Mental Health and Substance Abuse Services (DMHSAS). The HSRS is the only system that includes client-level data describing all clients served in the public system and the data is the primary source for federal Uniform Reporting System (URS)/National Outcome Measures (NOMS)/Treatment Episode Data Set(TEDS) reporting to SAMHSA.

The HSRS contains demographics, services, functional status and outcomes data on a client-level basis for mental health and substance abuse clients. Consumer demographics include name, gender, race, ethnicity, date of birth, and descriptive information such as DSM-IV diagnostic impression, SMI/SED status, primary drug of abuse, and age of first substance use. Both DSM-IV and ICD-9 diagnostic codes are currently accepted in the HSRS data system. Efforts are currently underway to convert to the ICD-10 codes as soon as possible.

The services data includes the types of services received, service units, service dates, provider ID, and service closing reason. The service data is collected on a summary basis for some services such as outpatient as opposed to a detailed encounter basis. Currently, the HSRS data system uses Wisconsin-specific service codes to describe the services received. The services data are recorded throughout a client's episode of treatment.

Mental health client functional status data is collected only for children with severe emotional disturbances (SED) and adults with a serious mental illness (SMI). Twelve functional status data elements are collected including living arrangement, employment status, daily activities, criminal justice system involvement, suicide risk, and health status. Consumer functional status data is collected at admission and then every six months for as long as consumers are receiving services. Substance abuse client functional status data is collected only for people who need more than brief services. For these clients, functional status data is collected at enrollment and discharge. The data collected includes living arrangement, employment status, criminal justice system involvement, support group attendance, and substance use frequency.

Wisconsin currently uses the services of a fiscal agent to support its Medicaid Management Information System (MMIS). The MMIS collects highly detailed information on Medical Assistance (MA) claims for services in the Medicaid fee-for-service system. This includes cost of services, services used, type of service, type of provider, place of service, dates of service, units of service, and more. Specific types of prescription drugs are recorded in the system as well as the amount and dates of usage. Because the Medicaid data is used for the purpose of billing, it is a reliable source of service and cost data for mental health consumers who use Medicaid benefits. However, the Medicaid data system is not designed to accept data describing the client's health status at admission or over time. The PPS system described below does have some integration with the state Medicaid Management Information System with regard to unique client enrollment and provider numbering.

Third, Wisconsin's Functional Screen Information Access system is a secure, web-based application used to collect information about an individual's functional status, health and need for assistance for various

Medicaid and other programs that serve the frail elderly, people with disabilities and persons with a mental health condition. The screen is used to determine functional eligibility for certain mental health services, adult long-term care programs and children's long-term support programs. Experienced professionals, usually social workers or registered nurses, who have taken an on-line training course and passed a certification exam are able to access and administer the screen. The screen automatically refers individuals who have co-morbid substance abuse issues to a level one screen for UPC (uniform placement criteria). This UPC tool provides criteria for completing a referral for a complete substance abuse (SA) assessment at an appropriate level of care. The MH/SA functional screen will also refer individuals with physical health problems and related activities of daily living deficits to a long term care functional screen to determine eligibility for funding through a home and community- based waiver. Data from the functional screen can be aggregated for program evaluation and quality improvement purposes.

Client-Level Data Capacity

The current HSRS data system collects primarily client-level data on consumers which are compatible with the client-level data submission requirements for the block grants. However, the HSRS uses an antiquated technology that is aging and expensive to manage. In addition, while consumer demographic and outcome data are recorded in client-level format, service utilization data are recorded at a summary level for each consumer.

For these reasons, Wisconsin is in the process of replacing HSRS with a new database (called PPS) having two methods of data submission for local reporting agencies. The first data submission method is a set of web-based data entry screens that reporting agencies can use to key their data if they don’t have their own local information system. Small, rural counties are most likely to use this method to submit their data to the State. This web-based direct data entry system will allow counties to record services at a detailed encounter level and will also have a page dedicated to mental health consumer outcomes including the NOMS. The outcome measures will be updated by providers every six months as long as a consumer is receiving services. Most of the 2011 mental health Data Infrastructure Grant (DIG) funds and State Outcomes Monitoring and Management System (SOMMS) funds have been spent to design and test this system. The PPS web data system was released for county provider use in June, 2012. The release marks the beginning of Phase 1 of the process which includes the implementation of the new information technology and the current HSRS data system elements. The new CMHS-required NOMS (school attendance, grade level, and 30-day arrests) are scheduled to be implemented into the new data system in Phase 2 in 2013. The official release of the new NOMS by CMHS in late October 2011 was too late for Wisconsin to incorporate into Phase 1 of its new data system. Thus, the new measures will be implemented in the data system in 2013 and collected by county providers in 2013.

The second new data submission method is an encounter-based batch file submission system requiring reporting agencies to submit XML-formatted files. This method encourages local reporting agencies to record data in their own local information system rather than record data in State-provided data entry screens. The data can then be uploaded from the provider’s local information system to the State agency. Larger county providers who can afford their own information systems will be the typical user of the batch file submission system. The PPS batch file upload system was released for county reporting agency use in October, 2012. Similar to the PPS web data entry system, the new mental health NOMS data will be added in the Phase 2 of the development of the batch file data system in 2013 and county providers will submit the new NOMS data in 2013. All current MH/SA NOMS data will continue to be collected in the new data systems.

Electronic Health Records (EHR)

Wisconsin has designed its previously described PPS data system similar to an electronic health record. It

has a unique enrollment process and client numbering system, screens that resemble an electronic health record, individual search and record management functionality, and, in general, the basis for each record is the individual client. Individual client records can be printed but also aggregate reports on service utilization and outcomes can be accessed. The system will adhere to Health Insurance Portability and Accountability Act (HIPAA) and other related federal EHR requirements. The DMHSAS is also promoting local agency adoption of electronic health record and practice management systems through small innovation and quality improvement projects.

Wisconsin is developing an eHealth system through collaboration among the state's public and private health care purchasers. The Wisconsin Collaborative for Healthcare Quality, the Wisconsin Health Information Organization, the Wisconsin Medical Society and the Wisconsin Hospital Association, major insurers and provider organizations are collaborating on the measurement and reporting of health care quality and costs. Wisconsin's work on eHealth is aligned with federal goals and activities in other states.

Wisconsin has a five-year plan which contains recommendations, plans, and timetable to achieve the goals set out in the Governor's Executive Order for statewide health data exchange between payers, health care providers, consumers of health care, researchers and government agencies. It also recognizes the essential role of consumers and patients and seeks to empower and support individuals to take responsibility for their own health. It balances privacy rights with providers' needs to share information for safe, effective treatment.

The plan weaves together three strategies to take a coherent, whole-systems approach to transformation of the health care sector:

- Improve quality, safety and value by establishing the eHealth technology platform to provide needed information at the point of patient care.
- Encourage the development, alignment and implementation of value-based purchasing policies and actions across the public and private sectors.
- Link health information technology (HIT) and health information exchange (HIE) plans to prevention and disease management activities.

These strategies have guided the activities of the initiative since 2006. They rely on joint public-private ownership with active collaboration and coordination of related system improvement efforts. The eHealth action plan components include:

1. Establish the eHealth technology platform.
    a. HIT adoption.
    b. Regional HIE.
    c. Statewide HIE services.
2. Value-based purchasing policies and actions.
3. Link HIT and HIE plans to prevention and disease management activities.
4. Take an incremental approach-growing thoughtfully over time with frequent evaluation of progress.

Barriers to Implementing Encounter-Based Claims Systems

The DMHSAS is both the State Mental Health Authority (SMHA) and Single State Authority for substance abuse (SSA). Since Wisconsin has a state-administered, county-operated service system, funding is mostly distributed in the form of competitive grants and grants-in-aid to local County agencies based upon a formula approved by the Legislature. Neither the SMHA nor SSA utilizes a claims-based approach to funding sources. However, if the SMHA/SSA were to implement an encounter-based claims

system, DMHSAS could modify PPS and draw on the existing Medicaid data system technology for this purpose.

Technical Assistance Needed

No technical assistance is requested by Wisconsin at this time in the area of data and information technology.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Section IV: Narrative Plan

R. Quality Improvement Plan

The Division of Mental Health & Substance Abuse Services (DMHSAS) will continue initiatives to refine and improve its performance measurement and data collection/analysis strategies, in order to better assess the level of adult and youth behavioral health across the State. One major initiative is to establish a system that more completely captures both the population accessing mental health and substance abuse services, and the nature of the services being provided. The Wisconsin Human Services Reporting System (HSRS) only collected data for those receiving services through county-based systems and programs, excluding others served in the private sector through free clinics or Federally Qualified Health Centers, and those receiving private sector services through public Medicaid or private insurance. Moreover, the data collected through HSRS has been primarily client-level, meaning that service data was collected on a summary basis (i.e., monthly summaries of hours of services) rather than on a detailed-encounter basis.

However, HSRS has been replaced by a new reporting system, Program Participation System (PPS), which provides several advantages. First, PPS accommodates the collection of service encounter-level mental health and substance abuse data, enabling users to identify exact dates of service. Encounter-level service data includes a record for every service encounter a client receives, unique individual identifiers, dates and types of service, units of service, and name of provider. PPS will also allow county and local providers to continue reporting client-specific demographic, services, outcomes, and performance indicators such as admissions, average units of service, services to underserved populations, and treatment completion to guide statewide quality improvement efforts.

Second, PPS encourages county and contracted providers to record state and federal mental health data in their own local information systems instead of in State-level data entry screens. Data is then transferred to the State information system, but the providers still have access to the data in their local systems, facilitating data analysis and quality improvement. Moreover, counties and contracted providers that do not yet have their own local information systems can access a web-based direct data entry site administered by the State. Use of the new PPS will increase data quality, increase the quality of feedback reports to counties, and enable the State to more effectively implement quality improvements, and create more flexibility in adapting State data systems to changing requirements.

The collection and measurement of indicators reflecting the performance outcomes, and fidelity to, various evidence-based practices and programs remains a challenge for DMHSAS. The Division of Quality Assurance within the Wisconsin Department of Health Services (DHS) provides periodic site visit surveys of programs for compliance with state law and administrative codes. That Division, however, does not have authority to evaluate adherence to evidence-based practices in certified programs. Recently, DMHSAS hired additional contract specialists to coordinate Division efforts to improve the contract-making process and to promote easier, more efficient sharing of contract process, fiscal, and performance outcome information among Division staff, counties, vendors and other service providers. Part of these new efforts include improving the use of existing database systems; interfacing data from those systems with online information management platforms (such as Microsoft Office's SharePoint) to enable more expeditious sharing of Requests for Proposal (RFP) and submissions, contracts, and performance reports; cataloging the many different performance measures and performance/progress reports utilized by DMHSAS; and training Division staff on effective use of these database systems and information platforms. These initiatives are designed to improve the Division's capacity to develop relevant and meaningful outcomes and performance indicators, track progress and accomplishments of numerous contract projects, and make reliable, valid findings relative to the effectiveness of project services and their impact on the mental health and substance abuse needs of clients

Two NIATx quality improvement (QI) initiatives are under way in Wisconsin. Using the Plan-Do-Study-Act QI model, 50 substance abuse and mental health agencies are collaborating to improve access to and retention in treatment and improve treatment outcomes. The 50 agencies develop and implement their own QI projects in their agencies with support from the DHS, outside experts and each other. As a result of this on-going effort, waiting times to enter treatment have been reduced and the rate of treatment completion has increased. In addition, ten County mental health agencies are collaborating to reduce re-admissions to inpatient psychiatric hospitals with promising results.

The DMHSAS also consists of the Client Rights Office (CRO), whose primary responsibilities focus around ensuring that persons receiving inpatient or outpatient services for mental illness, developmental disability, or substance abuse have their federal or state rights protected. The CRO specifically investigates and determines whether client rights have been violated, and shares its findings with service providers and facilities for the purpose of resolving disputes and violations. The CRO implements and oversees a four-level client rights grievance process for processing complaints made by service recipients of the State's two mental health institutes, two secure treatment centers, and three Centers for the Developmentally Disabled, as mandated by s. 51.61(5), WI Statutes, and Administrative Code DHS 94 for patient rights and resolution of patient grievances. (The four-level grievance process includes: Level I – Program Level Review; Level II – County Level Review; Level III and IV – State Level Reviews.) In addition, the CRO staff includes the State Grievance Examiner, who is responsible for conducting Level III grievances. The CRO also consults with and coordinates training activities for service providers, county agencies, department staff, clients and guardians regarding client rights and DHS 94 grievance resolution procedures.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

Section IV: Narrative Plan

S. Suicide Prevention

Wisconsin Suicide Prevention Strategy

The Department of Health Services (DHS) and the Division of Mental Health and Substance Abuse Services (DMHSAS) recognize the importance of addressing the problem of suicide in Wisconsin and are committed to updating Wisconsin's prevention plan. The State's most recent plan, the Wisconsin Suicide Prevention Strategy issued in May 2002, was developed by DHS (formerly the Department of Health and Family Services) in partnership with many other public and private stakeholders. A similar group is being convened to revise the plan. The revision process began in January 2013 following the release of the September 2012 updated National Strategy for Suicide Prevention. DHS and DMHSAS will use the 2012 National Strategy as a guide for updating the Wisconsin Suicide Prevention Strategy, as well as following the SAMHSA document Guidance for State Suicide Prevention Leadership and Plans. Presently it is planned to have the updated Wisconsin Suicide Prevention Plan completed by Suicide Prevention Week in September. Efforts continue in Wisconsin toward assertive suicide prevention efforts.

Mental Health America of Wisconsin (MHA) is the lead contracted agency for MHBG-funded prevention and early intervention activities. MHA staff provides leadership to Prevent Suicide Wisconsin (PSW), the public-private statewide coalition through support of the work of the PSW Steering Committee. The steering committee met four times in FFY 2012. Their major activities were to support the implementation of the 2nd annual Communities in Action to Prevent Suicide Conference (AFSP) (see below), promote survivor support group training (a training sponsored by AFSP was held in Madison in August), advise on criteria for the suicide prevention awareness week grants, and support fund development efforts. MHA presented five teleconference/webinars during the year for local coalition members and other interested persons. The topics included: Lesbian, Gay, Bisexual, and Transgender (LGBT) and suicide; Alcohol and Other Drug Abuse (AODA) and suicide; trauma and suicide; Suicide Care in a Systems Framework (based on the report from the National Action Alliance on Suicide Prevention); and Department of Public Instruction suicide prevention efforts. Information dissemination was also provided at a minimum of every other month through the PSW e-newsletter.

MHA staff continues to provide training and technical assistance to local suicide prevention coalitions. Twelve counties were provided technical assistance or participated for the first time in PSW activities this year. Representatives from 36 Wisconsin counties participated in the annual conference. Mini-grants were awarded to six communities to support public awareness and community education during or around Suicide Prevention Awareness Week in September.

Training continues to be a focus of MHA's efforts. In FFY 2012 MHA provided a training of trainers in Question, Persuade, Refer (QPR), a gatekeeper training program, to 42 individuals through trainings in the counties of Door, Nekoosa, and Menominee. Evaluations of these trainings have averaged 4.6 out of 5. In addition, MHA began efforts to create a stronger support network for trainers by work with the QPR Institute to create an up-to-date listing of Wisconsin trainers, which was posted to the MHA website, and surveying trainers on their needs. This will form the basis of ongoing communication efforts via email and teleconferencing. MHA supports local QPR training efforts by facilitating bulk printing of QPR books allowing local coalitions to obtain these at significantly less cost than they would have to pay if purchased through the QPR Institute.

MHA provided over 70 additional trainings and educational events to school groups, employers, church groups, health care providers and other organizations reaching over 2000 individuals. MHA staff were

also present at a variety of health fairs and conferences including the National Alliance on Mental Illness (NAMI) Conference, the Wisconsin Psychiatric Association annual meeting, the Crisis Intervention Conference, the Wisconsin Institute for Healthy Aging Prevention Summit, and the Boys and Girls at Risk conference. The second annual Communities in Action to Prevent Suicide Conference drew 160 attendees, up significantly from the prior year. Breakouts included LGBT youth issues, veterans issues, law enforcement training, faith-based suicide prevention, survivor support and coalition discussions. On a scale of 1-5 with 1 being "strongly agree" attendees rated the following statement a 1.7: "overall the conference was extremely valuable to me and to suicide prevention in my area."

MHA continues involvement in veteran's suicide prevention. MHA initiated a quarterly e-newsletter on veteran's behavioral health, collaborated with DryHootch on development and maintenance of an online resource directory for veteran's services and supports, and again partnered with Easter Seals on their Camp Yellow Ribbon.

The Prevent Suicide Wisconsin website is a repository for information specific to suicide prevention. A map links people to their local crisis line and local coalition, if one exists. The website also houses all of the webinars, public service announcements, and links to other relevant information.

Other MHA activities in FFY2012 included:

- Coordination with the Wisconsin Prevention Network, Wisconsin United for Mental Health (WUMH), the statewide Crisis Network and other mental health consumer and family advocacy groups.
- Collaboration with Kenosha County on their grant from the Medical College of Wisconsin and their successful application for continued funding to support suicide prevention.
- Successful completion of a development grant from the Wisconsin Partnership Program at the University of Wisconsin School of Medicine and Public Health to create a strategic plan for workplace mental health practices.
- Completion of an American Sign Language adaptation of the Signs of Suicide (SOS) video with Wisconsin School for the Deaf and participation with the Wisconsin Office of the Deaf and Hard of Hearing on development and implementation of a statewide summit on mental health and substance use disorder services for the deaf, deaf-blind, and hard of hearing.
- Continued work with the Department of Children and Families (DCF), the Department of Public Instruction (DPI) and the Department of Health Services (DHS) on an MOU for local agencies coordinating suicide prevention across child welfare, schools and human services.

In July MHA was awarded a Garrett Lee Smith Youth Suicide Prevention grant for approximately $480,000/year over three years from the federal Substance Abuse and Mental Health Services Administration. This grant will support targeted efforts aimed at veterans, LGBT youth and the Deaf/Hard of Hearing (D/HOH) population, as well as better integrating training efforts around suicide prevention into child welfare and school systems. The grant will also support three "model communities" that will integrate an array of best practices in suicide prevention.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

Section IV: Narrative Plan

T. Use of Technology

The Wisconsin Division of Mental Health and Substance Abuse Services (DMHSAS) has utilized several strategies to support recovery in ways that leverage Information and Communications Technology (ICT). The use of TeleHealth in Wisconsin has been increasing since 2007 to help address the Workforce need. Psychiatry services in particular are lacking in many rural areas, but may be in surplus in some urban areas such as Dane County. The table below details the number of TeleHealth certifications in 2012 for an array of Mental Health/Alcohol and Other Drug Abuse (MH/AODA) services. The actual number of providers offering TeleHealth is less than the 113 certifications as some providers are certified to provide multiple TeleHealth services. TeleHealth is used approximately twice as much for mental health services compared to substance abuse services. Although there is room for expansion among all services, TeleHealth appears to be currently used more often for regular outpatient services and less for emergency or crisis services and psychosocial rehabilitation programs such as Comprehensive Community Services (CCS) and Community Support Programs (CSP). Increased use of TeleHealth in CSPs could increase treatment capacity and reduce the use of wait listing, currently a barrier encountered by some consumers in Wisconsin.

Number of MH/AODA TeleHealth Certifications 2012

Type of Service	# of Certifications
DHS 35 MH Outpatient	46
DHS 40.11(2)(a-c) Children's Day Treatment	13
DHS 34.3 MH Crisis	10
DHS 63 CSP	6
DHS 36 CCS	3
DHS 61.75 Day Treatment	2
DHS 75.13 AODA Outpatient	23
DHS 75.05 AODA Emergency Outpatient	6
DHS 75.12 AODA Day Treatment	2
DHS 75.14 AODA Transitional Residential	1
DHS 75.04 AODA Prevention	1
Statewide Total	**113**

Wisconsin also has certification procedures for TeleHealth in Crisis, outpatient, CSP, and CCS. There are ten crisis programs that, in addition to their DHS 34, Sub III certification, also hold TeleHealth certification. The BPTR will be offering more training and outreach opportunities via internet-based and distance learning options, such as through Adobe Connect. The DHS has a support Information Technology staff who are available to train bureau staff on the use of the technology.

Another ICT strategy utilized by the DMHSAS has been conducted through the Strengthening Treatment Access and Retention Quality Improvement program (STAR-QI). This program provides information and support to County agencies and substance abuse treatment providers for the implementation of electronic health records, electronic outcomes measurement and smart phone uses in treatment and aftercare. The STAR-QI program has been successful in enabling several County agencies and providers to implement these ICT tools to improve recovery.

The Women's AODA Treatment Program has employed a variety of strategies to support recovery by utilizing ICTs. The Women's Treatment Coordinator uses Microsoft Live Meeting and Videoconferencing, Adobe Connect, and Web Casting to facilitate communication and improve access to providers. While over 80% of the Women's treatment programs have websites, several programs have incorporated social media resources as well. The Wisconsin Fetal Alcohol Spectrum Disorders (FASD) Treatment Outreach Project (WTOP), in addition to a website, utilizes podcasting and a Facebook page to provide information on topics related to Pregnancy and Alcohol, Substance exposed infants, screening and brief intervention techniques for Physicians and allied health professionals. The Wisconsin Women's Education Network (WWEN) and Wisconsin Women's Health Foundation's (WWHF) My Baby & Me utilize websites with electronic Newsletters. The Meta House, a nationally recognized, gender-responsive substance abuse treatment program dedicated to helping women through the progression of recovery, operates a website and utilizes Facebook and LinkedIn. Additionally, the organization uses Goodsearch and Goodshop for donations.

Community Recovery Services (CRS) is developing technological innovations to speed consumer service plan processing time, and disseminate new and useful information to stakeholders. CRS is using internet-based posting and a list-serve to keep steady communications with CRS sites. In addition, Adobe Connect is used to bring CRS teams together via remote online meetings. Most recently, the latest initiative involved the creation of an electronic case file (ECF) for all CRS consumer records. Integral to this initiative is a procedure by which counties and tribes are encouraged to submit an entire consumer service plan packet electronically via the State's newly implemented encrypted email system. The ECF exists on the secure internal computer system of the Department. The CRS Team is creating both policy and procedure to address issues such as record retention, Health Insurance Portability and Accountability Act of 1996 (HIPAA)/ Health Information Technology for Economic and Clinical Health (HITECH) compliance, cataloging, and work-in-process. ECF will be accessible by all CRS Team members simultaneously, and will also be accessible from remote locations via the Department of Health Services' (DHS) secure virtual private network (VPN). Adobe Acrobat technology allows physical files to be scanned into an electronic format. Submission of consumer service plans via the State's encrypted email system is expected to be a very valuable and popular procedure for Wisconsin's counties and tribes. Encrypted email is deemed to be both HIPAA and HITECH compliant, and the labor and cost savings related to the management and retention of physical records is expected to be significant over the lifetime of the benefit.

Budget and staff limitations may be a barrier to implementing large scale new interactive technologies that require a sizable financial investment upfront. Smaller changes, such as those underway, may decrease costs via reduced staff travel costs.

Wisconsin is developing an eHealth system through collaboration between the state's public and private health care purchasers. The Wisconsin Collaborative for Healthcare Quality, the Wisconsin Health Information Organization, the Wisconsin Medical Society and the Wisconsin Hospital Association, major insurers and provider organizations are collaborating on the measurement and reporting of health care quality and costs. Wisconsin's work on eHealth is aligned with federal goals and activities in other states.

Wisconsin has a five-year plan which contains recommendations, plans, and a timetable to achieve the goals set out in the Governor's Executive Order for statewide health data exchange between payers, health care providers, consumers of health care, researchers, and government agencies. The plan also recognizes the essential role of consumers and patients, and seeks to empower and support individuals to take responsibility for their own health. Additionally, the plan balances privacy rights with providers' needs to share information for safe and effective treatment.

The plan weaves together three strategies to take a coherent, whole-systems approach to transformation of the health care sector. The strategies rely on joint public-private ownership with active collaboration and coordination of related system improvement efforts. The eHealth action plan components include:

1. Establish the eHealth technology platform.
    a. Health Information Technology (HIT) adoption.
    b. Regional health information exchange (HIE).
    c. Statewide HIE services.
2. Value-based purchasing policies and actions.
3. Linkage of HIT and HIE plans to prevention and disease management activities.
4. Taking an incremental approach by growing thoughtfully over time with frequent evaluation of progress.

A few counties in Wisconsin have begun to partner with Federally Qualified Health Centers (FQHCs) to provide a more integrated approach and to better link primary care to their behavioral health services. The BPTR has met with the statewide association that supports FQHCs to deliver Screening Brief Intervention and Referral to Treatment (SBIRT), depression and tobacco screening and intervention.

The Human Services Reporting System (HSRS) is Wisconsin's electronic client information system and database that is used to populate the Federal Treatment Episode Data Set (TEDS). Community addiction service providers collect demographic, client profile, service utilization and National Outcomes Measurement System (NOMS) outcome data and report it to their respective county human service agencies. The county human service agencies submit the HSRS data to the state via direct data entry into the HSRS internet-based sites or via batch file submission online. The DHS maintains the HSRS database and extracts quarterly files for upload to the TEDS system.

Efforts have been underway to upgrade the technology behind the Human Service Reporting System (HSRS) utilizing the Data Infrastructure Grant (DIG) to improve Wisconsin's data collection needs. The HSRS is being replaced by a more technologically state-of-the-art system that allows both uploaded data and direct web-entered data. The new data system encourages all providers to record data in their local information systems as opposed to recording data in State data entry screens only. Data can then be transferred from a provider's local information system to the State. Additionally, the Wisconsin DHS is developing a web-based direct data entry system administered by the State to provide support to counties and contracted providers who initially lack the capability to record mental health and substance use data in their local information system. New permanent dual options for data entry and submission will be available for counties to choose from depending on their local information technology capacity. Updating the technology and building routine output reports have been Phase 1 of the project. In Phase 2, to be implemented over the next year, new data elements will be added to improve the type of data that is collected for the monitoring of client outcomes.

The Substance Abuse Prevention Services Information System (SAP-SIS) is a web-based data collection tool developed by the DMHSAS to collect federally required Substance Abuse Prevention and Treatment Block Grant (SAPTBG) prevention data from state grantees, including counties and tribes, who receive SAPTBG dollars. Funded agencies use SAP-SIS to report on required data from their prevention efforts throughout the contract year. After registration, agencies may access SAP-SIS at any time to enter data or review previously submitted data. DMHSAS requires that funded agencies submit their SAP-SIS reports on an annual basis. Data collected through SAP-SIS is used by the State of Wisconsin to fulfill annual SAPTBG reporting requirements.

Wisconsin has an initiative underway to improve performance measures. We have developed workgroups, hired staff, and evaluated current processes. Over the next year we will be continuing to improve the process of evaluating effectiveness. We will include the use of ICTs in that process.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

Section IV: Narrative Plan

U. Technical Assistance Needs

Perception of Care

Publically funded and certified substance abuse treatment programs in Wisconsin are required to collect client information pertaining to their perception of care. However, this information has not been sent to the Single State Agency on Substance Abuse. The Bureau will examine how this information could be standardized and collected at the state level and used to improve services. The Bureau could use technical assistance from SAMHSA on how to proceed and still assure the state meets the federal standards of confidentiality.

Workforce Development

Wisconsin has an aging workforce of substance abuse counselors. Concerns have arisen about having an adequate workforce trained to meet the increasing need to bill private insurance as parity and health care reform assure more coverage of individual's needs for substance abuse disorder treatment. SAMHSA has produced a paper that looks at a model scopes of practice that states might consider to retool and further develop their workforce. No one agency in Wisconsin owns this issue as it spans the responsibility of the Department of Safety and Professional Services who licenses professionals, the universities and colleges that train the workforce, and the Departments such as Department of Health Services, Department of Corrections that contract for or oversee programs that provide substance abuse treatment services. Technical Assistance from SAMHSA may be helpful to convene these various entities to begin to plan for the future of substance abuse counselors in the state.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

Section IV: Narrative Plan

W. State Behavioral Health Advisory Council

The State of Wisconsin has two Governor appointed advisory councils which play a role in the planning of the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Plan, the Wisconsin Council on Mental Health (WCMH) and the State Council on Alcohol and Other Drug Abuse (SCAODA). The WCMH is legislatively mandated under section15.197 (1), Wisconsin Statutes, as the mental health planning Council for the State. It was created to advise the Governor, the Legislature and the Department of Health Services (DHS) on the allocation of Mental Health Block Grant funds. The Council consists up to 25 members appointed by the Governor, and meets bi-monthly. The Council is recruited and staffed so that at least 50 percent of the members are consumers and/or family members. Other members represent state agencies, mental health providers, and other organizations or groups. Due to recent retirements and resignations, currently the Council consists of 19 members, eight of which are not state employees or providers. Of these eight, one person is an advocate, five people are consumers (individuals in recovery), and two are parents of children with serious emotional disturbance (SED). Also serving on the Council are four providers of mental health services, a representative from the state agencies responsible for the following services: corrections, education, housing, Medicaid, mental health, social services, and vocational rehabilitation. The Council, the DHS and the Governor's Office continue to recruit new members of the Council and strive to maintain a diverse group of representatives to serve on the Council.

The WCMH has several duties and responsibilities, as specified in section 51.02 of Wisconsin Statutes. The Council evaluates and reviews the Wisconsin mental health system's progress towards achieving improved client outcomes and the adequacy of mental health services in the State. The Council also oversees state compliance with federal Public Law 102-321. In addition, the Council participates in developing, monitoring, and evaluating the implementation of the state Block Grant plan. Other duties include reviewing all DHS plans for services affecting persons with mental illness, monitoring implementation of the plans, and serving as an advocate for persons of all ages with mental illness. The Council operates six committees: the Executive Council Committee, the Adult Quality Committee, the Children and Youth Committee, the Criminal Justice Committee, the Legislative and Policy Committee, and the Nominating Committee. Members of the Council are joined on these committees by additional advocates, individuals with lived experience, and family members of persons with mental illness.

The SCAODA was created by the enactment of 1993 Wisconsin Act 210 and is focused upon the coordination of substance abuse planning and funding in Wisconsin. The council consists of 22 statutory members and ten Ex Officio members representing most cabinet level agencies in Wisconsin, two constitutional offices, the Legislature, service providers and citizens.

SCAODA's membership includes representatives from the DHS and the DHS Secretary's Office; Secretaries, or their designees, from the Wisconsin State Departments of Transportation, Public Instruction, Corrections; the Governor's Office; the Commissioner of Insurance; the Attorney General's Office; the Pharmacy Examining Board; the Wisconsin County Human Service Association; the Governor's Law Enforcement and Crime Commission; four State Legislators and six citizen members. In addition a number of other ex-officio members routinely participate including staff from the WCMH.

Staff from the Division of Mental Health Substance Abuse Services (DMHSAS), within the DHS, are legislatively designated to provide staff support to both Councils. As a result SCAODA's plans, recommendations, motions, commendations, and Public Forum testimonials are all a part of the conduit between SCAODA, and state departments and agencies. Advising on issues relating to substance abuse services is in fact a statutory purpose of SCAODA.

The purpose of the SCAODA is coordinate substance abuse planning across the many agencies in Wisconsin government. The Council is responsible for reviewing pending legislation, developing a four-year plan to implement Council priorities, reviewing the biennial budget and making recommendations to the Governor and Legislature. The SCAODA has five standing committees, and one sub-committee, which focus upon prevention, treatment, planning/funding, issues pertaining to diversity of substance abuse needs among state residents, and coordination between member departments regarding alcohol and other substance abuse activities. These committees are: the Cultural Diversity Committee, the Inter-departmental and Coordinating Committee, the Intervention and Treatment Committee, the Children, Youth and Family Sub-Committee, and the Planning and Funding Committee.

The SCAODA and the WCMH have decided not to merge at this time, however various efforts have been made to better coordinate and integrate efforts. These include co-membership of the WCMH and SCAODA Children and Youth Committees, ex-officio members of WCMH participating on the SCAODA and SCAODA committees, and ongoing collaboration between the WCMH and SCAODA Executive Committees. A key component of WCMH and SCAODA collaboration has been the WCMH/SCAODA Ad-Hoc Needs Assessment Committee, which played a major role in the planning of Wisconsin's Mental Health and Substance Abuse Needs Assessment, and the Wisconsin BG plan.

Planning efforts began in early April 2012 as the development and implementation of a mental health and substance abuse needs assessment which could be utilized as a guiding document for the State Block Grant plan. A collaborative committee of representatives from the WCMH, SCAODA, and the Wisconsin DHS was formed. This group became the Ad Hoc Needs Assessment Committee, and was tasked with the design and planning of the needs assessment. This needs assessment was designed to act as a standalone tool for the state's mental health and substance abuse services and inform Wisconsin's Block Grant plan. The Ad Hoc Needs Assessment Committee convened throughout 2012 and into early 2013.

The process was intended to identify the strengths, weaknesses, and gaps in the mental health and substance abuse services in Wisconsin with a goal of ensuring the state meet the needs of a high-quality life: health, home, purpose, and community. In addition, development of the needs assessment was done with mindfulness of SAMHSA's eight strategic priorities. This involved the identification of quantitative and qualitative sources of data, priority populations, and areas to examine. The goal of conducting the needs assessment was to identify needs in Wisconsin, determine populations at the greatest risk, and identify disparities. Additionally, the assessment was intended to determine if the mental health and substance abuse system is serving the needs, especially in regard to access and capacity. Consumer outcomes, along with the appropriateness and quality of services were also analyzed. Over the 2012 calendar year, with the guidance and support of this committee, DHS staff conducted the needs assessment, and produced a report of the findings.

Upon completion of a draft the needs assessment was provided to the committee for additional review and feedback. In early 2013 the needs assessment was presented to the WCMH and the SCAODA. Members of the WCMH and Ad Hoc Needs Assessment committee provided analysis of the needs assessment, identifying priority populations, mental health and substance use issues, and gaps in services. Upon identifying critical needs and gaps in service, the resulting list was ranked by each member of the committee to create a list of greatest priority mental health and substance abuse issues. This ranking and committee analysis was utilized to inform this plan.

The WCMH and the SCAODA both commented and evaluated the draft Wisconsin Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Plan. Staff from the DMHSAS presented the Wisconsin plan to both councils, and several committees throughout early 2013. Each council and committee provided feedback and critique of the plan. The Wisconsin plan, Needs

Assessment, and associated documents were also distributed to various stakeholders by the two councils. The planning and needs assessment documents were also available to members of the public on the WCMH website, and members of the public were encouraged to provide feedback and participate in public comment sessions, or to provide feedback to DHS via email. Opportunities for the public to comment on the Wisconsin Mental Health and Substance Abuse plan and the needs assessment were provided at the March 1, 2013 SCAODA meeting, and at the March 20, 2013 WCMH meeting. Both meetings were held in Madison, Wisconsin. A toll-free conference line was also available for members of the public to participate in these meetings.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Shel Gross	Others (Not State employees or providers)	Mental Health America of Wisconsin		
Sister Ann Catherine Veierstahler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mary Neubauer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Joann Stephens	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jo Pelishek	Parents of children with SED			
Edward Wall	State Employees	Department of Corrections		
Donna Wrenn	State Employees	Department of Administration		
Dave Stepien	State Employees	Department of Health Services		
Linda Harris	State Employees	Department of Health Services		
Kim Eithun-Harshner	State Employees	Department of Children and Families		
David Nencka	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Julie-Anne Braun	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mishelle O'Shasky	Parents of children with SED			
David Sommers	Providers	Arbor Place, Inc.		
Richard Immler	Providers			
Carol Keen	Providers	Wisconsin Housing Preservation Corp.		
Matt Strittmater	Providers	La Crosse County Human Services		
Kathleen Enders	State Employees	Department of Workforce Development		
Kathryn Bush	State Employees	Department of Public Instruction		

Footnotes:

Note: This membership list reflects Wisconsin Council on Mental Health as of 8/22/13

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	25	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	6	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	14	56%
State Employees	7	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	11	44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

Section IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

The Wisconsin Department of Mental Health and Substance Abuse Services understands the importance of assuring individuals with mental health and substance use disorders have access to the appropriate health insurance based on their particular needs. In Wisconsin, State law mandates that counties are responsible for providing mental health and substance abuse services when they have emergency and other needs. Counties and county income maintenance consortiums are also responsible in Wisconsin for enrolling residents in Medicaid health insurance and helping individuals who do not qualify for Medicaid to access the federal marketplace for health insurance coverage. Because of the counties' critical role in connecting people to health insurance Wisconsin will continue to work with counties to both cover those people not otherwise insured for mental health and substance abuse treatment and prevention, as well as assist people to access appropriate Medicaid and other health insurance benefits. Of the Community Mental Health Services Block Grant 36.8% of the Wisconsin award of $6,822,203 in the President's 2014 budget would go for those county mental health services. Of the $27.5 million of Substance Abuse Prevention and Treatment Block Grant in the President's 2014 budget for Wisconsin, 35.4% would go to county substance abuse programs. Because these allocations are related to statutes, Wisconsin will continue these allocations, providing information and assistance to the county programs as the Wisconsin process for enrollment in the federal marketplace unfolds.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Section IV: Narrative Plan

Y. Comment on the State BG Plan

Comment on the 2014-2015 Wisconsin Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Plan

The Division of Mental Health and Substance Abuse Services (DMHSAS) worked with the Wisconsin Council on Mental Health (WCMH) and the State Council on Alcohol and Other Drug Abuse (SCAODA) to facilitate an open process of review of the Federal Fiscal Year 2014-2015 Wisconsin Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Plan. A draft of the plan was reviewed by two WCMH committees—the Adult Quality Committee and the Children and Youth Committee and two SCOADA committees, the Intervention and Treatment Committee, and the Planning and Funding Committee. The plan was reviewed at a meeting of each council. Both meetings also contained an opportunity for the public to comment on the plan. The SCAODA meeting and opportunity for public comment was held March 1, 2013, and the WCMH meeting and opportunity for public comment was held March 20, 2013. The public was notified of the public comment opportunity through the state's official public meeting notification process and through email distribution lists. The plan was also reviewed by a group of representatives from the Tribes of Wisconsin. The plan was accessible to the public via download from SCAODA and WCMH websites, and members of the public were encouraged to provide comments via email or one of the two opportunities for public comment. The Wisconsin Council on Mental Health provided a letter in response to the block grant plan which is included (Appendix 3).

The following are comments received from the two councils, committees, and members of the public. The comments have been categorized and in some cases summarized. Responses from the DMHSAS are added at the end of each section.

Policy and Priority Comments

- **Homelessness**
  - Narrow definition is used.
  - Missing from priority areas.

- **Suicide Prevention**
  - Noted as a priority but not addressed in the goals.

- **MH/SA across the lifespan**
  - Important to include information about mental health and substance abuse across the lifespan.
  - The plan has a general lack of detail regarding aging.

- **Youth substance abuse**
  - A greater focus on children's services is needed.
  - Priorities in the Federal Block Grant do not address all of the priorities found in the 2012 Epidemiological Profile on Alcohol and Drug Use. An emphasis was placed on adding the priority of reducing underage drinking.

    - Reduce Alcohol related motor vehicle fatalities and injuries (especially among people ages 16 to 34)
    - Reduce Underage Drinking (ages 12-20)

- **Prescription Drug Abuse**
    - Focus on prescription drug abuse among tribal people.
    - Focus on treating families with co-occurring disorders.
    - Concern expressed about opiate/synthetic drug use among tribal populations.

- **Reduce Adult Binge Drinking** (ages 18-34)
    - Priorities in the Federal Block Grant do not address all of the priorities found in the 2012 Epidemiological Profile on Alcohol and Drug Use.

- **Psychiatrist Shortage**
    - A shortage of child psychiatry is a major issue and did not appear a lot on the ranked list and application.
    - Psychiatrist availability in northern Wisconsin is indicated as a problem but it is not included as a priority in the Block Grant application.

- **Implementation of the Affordable Care Act**
    - Do we have any strategies in place to monitor implementation of the ACA? If not, it sounds like this will need to be a part of our plan. Should this be added to our priorities?

DMHSAS Response

The 2014-2015 Wisconsin Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Plan includes eight Substance Abuse and three Mental Health priority areas. The DMHSAS selected these priority areas through a needs assessment process. The 2012-2013 needs assessment report presents a multitude of data-driven problems, issues, needs and gaps. Based on their experience, expertise and a review of the needs assessment report, stakeholders were asked to submit a list of the needs and gaps in Wisconsin's behavioral health system. The final combined list included 26 needs and gaps in services. These 26 needs and gaps in services were then rated by a group of stakeholders and State of Wisconsin staff utilizing a tool based on a public health program priority rating model.
Each need or gap was rated on the following characteristics: consumer functional impact, fiscal impact, volume of need, comparison to national benchmark, consumer priority, availability of knowledge and resources to address need, long-term trend direction, and federal priority. The ratings for each domain were summed in the calculation of the overall rating for an item. Overall item ratings were then averaged across all stakeholders.

These rankings were utilized to inform the objectives, strategies and performance indicators selected and developed for the Wisconsin Block Grant Plan. Priorities were selected by a group of DMHSAS staff. Factors which were considered in the selection process included overall ranking of needs, best fit of needs with block grant priorities, qualitative and quantitative review, and an assessment of the feasibility of impacting the need through utilization of block grant funding. Moreover, SAMHSA requires states to address several priorities areas through the block grant funding which are included in Wisconsin's priorities.

To ensure the State meets SAMHSA requirements, Wisconsin has utilized SMART (Specific, Measurable, Achievable, Realistic, and Time-sensitive) objectives in Block Grant Plan. DMHSAS has selected priorities which address critical needs and gaps in services identified in Wisconsin while ensuring SAMHSA criteria and priories are also addressed. It is important to note that though not all of the identified needs are addressed via the block grant plan, other resources may be directed towards addressing those issues.

Based on the comments received, DMHSAS has considered the following for addition to the block grant plan priority areas. Suicide prevention will be added as a priority area. The reduction of adult binge drinking will be added as priority, and the previously identified priority area of alcohol related motor vehicle crashes will be included as a goal of this new priority area. A goal to address youth substance abuse will be added as a component of the substance abuse in the criminal justice system priority. Heroin use and opiate related death will be included as components of the intravenous drug user priority area.

Strategy Comments

- Emphasize trauma informed care
- Emphasize recovery
- Evidence Based Practices (EBP)
    - EBPs should be utilized
    - EBP data reporting is critical
- EBPs endorsed
    - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
    - Focus on criminal justice interventions such as drug courts and wellness courts (Vilas Co).
    - Peer specialists
        - Peer specialists, peer-run recovery centers and peer-run respites are all evidence based, and all highly valued by people receiving mental health services.
        - Parent peer specialist
        - The establishment of peer specialists as one-to-one advocates and mentors is important.
            - They appear to improve engagement and recovery outcomes.
            - A key factor in their success may be to establish a way to employ them independent of institutions, counties or hospitals, to minimize the conflict between interests of their employers and interests of the peers with whom they partner.
    - The amount of funding for peer-run and peer-provider services shows that consumer-driven recovery is not a priority and not integrated into the vision that drives the planning.
    - Pyramid Model
- Increased use of performance measures

- Focus on priority areas related to improving outcomes through evidenced based practices/quality improvement initiatives, increasing professional workforce capacity, and early identification of those with adverse childhood experiences. These efforts will impact top priority rankings.

- Need to get families involved early in programming. Need family psycho-education opportunities.

- Involve people with lived experience in efforts to prevent prescription drug abuse, and educate families on IV drug use problems.

- Focus on employment opportunities for people in the criminal justice system jails and prisons.

- Consumer-Driven Recovery is a concept, ideal and value that has developed into a range of evidence –based practices and should be at the center of any planning involving mental health.

- In regards to consumer satisfaction, purpose and community were both reported to be important to consumers.

- Recovery and drop-in centers are a type of place that is scarce in most of our towns and cities.
    - Provide consumers a place to socialize without the barriers of social phobia or discrimination.

- Address barriers to accessing mental health or substance abuse treatment including costs, motivation, and transportation/distance by increasing access to medically necessary Medicaid reimbursed mental health intervention to children under the age of five in their natural environments, e.g., child care, home.

- Provide parents and helping professionals working with infants and young children (e.g., child care workers, home visitors, and pediatricians) the knowledge, skills and practices that support healthy social and emotional child development.

- Support the infrastructure of the developing infant and early childhood mental health competency and endorsement system.

- Require providers of early childhood services to be endorsed at the appropriate level.
    - Home visitors – Infant Family Specialist; Level II
    - Child welfare workers – Infant Family Specialist; Level II
    - Infant mental health clinicians – Infant Mental Health Specialist; Level III

DMHSAS Response

DMHSAS is committed to the promotion and use of evidence based practices (EBP), including peer-based services. Priority areas include strategies and goals which will encourage the use of EBPs throughout the Substance Abuse and Mental Health service delivery system at both the State and local level. Ongoing training will be geared toward the implementation and expansion of EBPs. SAMHSA requires the State to report the number of EBPs utilized. As such, DMHSAS anticipates prioritizing the

measurement of, the use of, and fidelity to, EBPs. DMHSAS is also committed to recovery oriented practices and will include recovery as a key component to programs and practices.

Process Comments

- Important to share the needs assessment and the MH/SA Block Grant plan with other stakeholder groups:
    - Organizations and boards such as the Wisconsin Association on Alcohol and Other Drug Abuse, Inc. (WAAODA) and counselor associations.
    - Stakeholders from infants and early childhood in the needs assessment process.
    - People with lived experience.
    - People with experience with the criminal justice system.
    - Meaningful Consumer Involvement needs to be a priority in developing the plan for use of community mental health block grant funds.
        - Gaining and sustaining meaningful consumer involvement takes time, money and sustained effort, but it is essential to establishing priorities and quality services.

- Distribution of the BG Plan
    - A comment from the public health perspective: This document should be presented to the Division of Public Health and share the process used to gather data and the ranking for educational purposes. This document could be shared through the whole department, not just within the program or bureau.
    - Can this application be sent to everyone within the department?

- As identifying needs via a needs assessment it may be beneficial to ask consumers "What helped you" to identify what services are beneficial for support and recovery.

DMHSAS Response

DMHSAS is committed to including stakeholders in the needs assessment and block grant planning and evaluation process. Initial steps were taken to involve stakeholders in the needs assessment process through the creation of the Ad-Hoc Needs Assessment Committee which was comprised of members of the Wisconsin Council on Mental Health (WCMH) and the State Council on Alcohol and Other Drug Abuse (SCAODA). This group guided the development of the needs assessment. Members of this committee also played a major role in the identification of the needs and gaps in services as indicated in the needs assessment and provided rankings of those needs and gaps. These rankings were a key factor in the identification of the block grant priority areas.

Members of the public, the WCMH, the SCAODA and associated committees were all provided with, and invited to comment on, the draft 2014-2015 Wisconsin Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Plan. The two Councils were encouraged to disseminate the block grant plan and associated documents through their networks of stakeholders for review and comment. DMHSAS is dedicated to an open and transparent needs assessment and block grant planning process. The Division will continue to explore means of increasing the involvement of stakeholders such as providers, consumers, and underserved populations in future block grant and needs assessment planning.

Comments received via the block grant review process will be taken into account for future planning to ensure stakeholders have the opportunity to provide input and feedback.

Technical Edits

- Clarify/define the criteria for women-specific treatment.
- Include additional language regarding recovery.
- It is not clear to what extent consumers are involved especially with the criminal justice priority for MH.
- The Housing and Urban Development (HUD)-funded Emergency Solutions Grant section can be updated.
- Wisconsin did not receive funding for the Real Choice System Change Grant.
- Important to note that Wisconsin is the only state that uses Block Grant monies for the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative.
- Medicaid
    - How has the Governors rejection of Medicaid expansion been integrated into the application?
    - Without Medicaid expansion it may be more difficult to receive mental health services and persons may end up being uninsured and potentially in need of services. This population may require additional supports via the block grant.
    - Will changes to Medicaid impact the responses and/or numbers presented in section D in regard to the number of individuals served under the grant s are uninsured in 2013 or who remain uninsured in 2014-2015?
- Tribal members don't usually have health insurance; they utilize the Indian Health Services instead. Is this accounted for any place?
- The HUD-funded Emergency Solutions Grant section can be updated. The issue with the HUD proposal has moved forward and Wisconsin was not chosen to participate.
- Add in the information regarding the regional changes under CCS which would be implemented under the Governor's budget.
- It is important to note the Division of Public Health as a partner in the trauma informed care, this would illustrate collaboration within the Department.
- Highlight the details of the Children's Trust Fund incorporating ACE into BRFS.
- Standardize the use of acronyms throughout the document.
    - Add a glossary of acronyms

- Level of information and data presented in the document varies topic to topic.
- Family Care discussion should include information about the concerns that have been raised about the adequacy of services to people with Mental Illness and some of the things that OFCE is working on in this regard.
- A bit more detail about what the “groupings” of homeless are and how that changed might add clarity.
- How come some of the highest ranked items did not become priorities: e.g. availability of psychiatrists and suicide prevention, both of which ranked higher than other things that were prioritized?
- Should goals include indicators for the number of counties that will have Comprehensive Community Services (CCS) and Coordinated Services Team Initiative (CST) and number of people served?
- For criminal justice goal why is this limited to county systems?
- There are needs to expand the Opening Avenues to Reentry Success (OARS) program and increase the number of MH professionals within the DOC.
- In regards to the disparities section should there be discussion of Healthy Wisconsin 2020 and the suicide prevention goal related to disparities, the D/HOH work, LGBTQ efforts with DPH and DPI?
- On page 78 there are a variety of peer run/delivered services for veterans. If these are not funded by the state are they still worth mentioning? We are collaborating with some through the PE grant.
- I would like to suggest that the number of consumers involved, the selection process and level of involvement be detailed in future.

DMHSAS Response

DMHSAS appreciates and will consider all technical edits and, if appropriate, will revise the block grant plan.

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary-Elect

March 13, 2013

Mike Huebsch, Secretary
Wisconsin Department of Administration
101 East Wilson Street
Madison, WI 53703

RE: Delegation of Signature Authority

Dear Secretary Huebsch,

As Agency Head and in accordance with the provisions of s.15.02(4), Wis. Stats, I hereby delegate signature authority to the following individuals for the particular documents indicated.

Kevin E. Moore, DHS Deputy Secretary
Andrew Hitt, DHS Executive Assistant

- ✓ Requests for Purchasing Authority
- ✓ Requests for Granting Authority
- ✓ Contracts entered into by any DHS organizational unit
- ✓ Memoranda of Understanding entered into by any DHS organizational unit
- ✓ Agreements entered into by any DHS organizational unit
- ✓ Grant Applications Submitted and Grant Awards Received

I will file updates to this list should there be a change in personnel in the delegated positions, when the level of specific delegation expands or contracts, or at any other time conditions warrant. Should you have questions regarding this transaction, please feel free to contact me.

Sincerely,

Kitty Rhoades
Secretary-Elect

CC: Rick Hughes, Director, State Bureau of Procurement, DOA
Kevin E. Moore, Deputy Secretary, DHS
Andrew Hitt, Executive Assistant, DHS
Cheryl K. Johnson, Deputy Administrator, Division of Enterprise Services, DHS
Jacqueline Sommers Smith, Bureau of Strategic Sourcing, DES, DHS

Appendix 1

Wisconsin

Mental Health and Substance Abuse

Needs Assessment

February 14, 2013

Wisconsin Department of Health Services
Division of Mental Health and Substance Abuse Services
Bureau of Prevention Treatment and Recovery

Introduction

Two Federal block grants bring some $7.5 million in mental health and $28 million in substance abuse services funds to Wisconsin each year. Federal guidance for the FY 2012-2013 mental health and substance abuse block grant application(s) require states to complete a data-driven behavioral health assessment and plan, hereafter referred to as the needs assessment. The intent of the needs assessment is to 1) assess the strengths and needs of the service system's response to specific populations; 2) identify the unmet service needs and gaps within the service system; and 3) develop priorities, objectives and strategies to address the identified needs and gaps.

Through the block grants, the Federal government desires to achieve "good and modern" state mental health and substance abuse service systems. A good and modern system is accountable, organized, controls costs, improves quality, is accessible, equitable, effective, prevents conditions, reduces cultural disparities, promotes individualized service plans, empowers and involves consumers, uses available technology, encourages natural support systems and establishes links with health care. Many of these attributes can be analyzed by this needs assessment. While the future of many healthcare reforms passed in the Federal Patient Protection and Affordable Care Act are still uncertain in Wisconsin, Federal guidance requests that the needs assessment address issues related to the changing healthcare environment and the impact on uninsured persons.

Needs Assessment Approach

For the purposes of the behavioral health assessment and plan, needs assessment will be defined as a "data-driven and systematic exploration and determination of the gaps between current conditions and desired conditions." The goal of the needs assessment is to develop a set of state-specific, data-driven and realistic priorities, objectives and strategies to address identified needs and gaps. The objectives selected must have measurable performance indicators associated with them and the measures must be tracked. Selected indicators from four broad categories of data and information will be collected and analyzed as part of this needs assessment. The indicators were selected based upon data availability and having been previously identified as a priority problem or need through Wisconsin surveys, studies or stakeholder or public input.

I. Population(s) Affected. This refers to the prevalence of disorders, conditions and associated problems for the entire population as well as for special populations such as the homeless, females, cultural groups, youth, older adults, veterans, rural populations and criminal justice offenders. This analysis will answer the questions, what are the problems, what is the extent of the problem(s), and what is the need for services, strategies, supports or treatment across different populations?

II. Access to Services, Strategies, Supports and Treatment. This analysis will answer the questions: Are populations able to gain entry to services, supports or treatment? Are prevention strategies in place in communities? Do people receive preventative, treatment or support services when (timeliness) and where (geographically available) they need it? What are the barriers to receiving services and strategies? What proportion of the population are recipients of services, strategies, supports and treatment (treated prevalence or penetration rate)?

III. Availability and Capacity of Services and Strategies. What types of services and strategies are needed and what is the capacity of the system (including number of providers and workforce characteristics) to meet the needs? What is the capacity of the system to provide a culturally and linguistically appropriate mix of services to meet the needs of the populations affected? Are the resources in the system appropriately aligned and cost-effective (i.e., relative use of more intensive inpatient care compared to other community based care)?

IV. The Quality, Outcomes and Impact (effectiveness) of Services, Strategies, Supports or Treatment. Do people receive "appropriate" preventative, treatment or supportive services? Are the services, strategies, supports or treatment of desired quality? Are the services or strategies safe, client-centered, efficient, equitable, evidence-based, effective or otherwise proven to work? What happened to the consumer and/or the system as a result of the interventions, strategies, services or supports? What is the impact? What is and is not achieved to ameliorate the condition, disorder or problem? Outcomes to be measured will also include what consumers believe are important to them as well as those outcomes important for the overall system.

A formal, combined mental health and substance abuse needs assessment committee consisting of members from the Governor-appointed Wisconsin Council on Mental Health and the State Council on Alcohol and Other Drug Abuse was established to provide guidance and direction about issues to examine, to review the analyzed data, provide a preliminary ranking of priorities and assist with developing strategies and performance indicators. A tool based on a public health program priority rating model[1] (Appendix A) was developed to rate and rank the gaps, issues and problems identified through the Wisconsin needs assessment.

Public and stakeholder input was sought through a brief 3-question survey asking about mental health and substance abuse needs, service gaps, problems and issues. Consumers, advocacy groups, service providers, Tribal agencies, veterans and county intermediary agencies submitted completed surveys (n = 72). These data are included in the analysis where appropriate and a summary is located in Appendix B.

The assembled data and information in this report come from a variety of primary and secondary data sources including the United States Census Bureau, National Survey on Drug Use and Health, Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System, CDC's Youth Risk Behavior Surveillance System, Wisconsin Mental Health Statistics Improvement Program (MHSIP) survey, Wisconsin County Public Treatment Form, Wisconsin Human Services Reporting System, Wisconsin Medicaid Claims database, Wisconsin Crime Information Bureau, Wisconsin Public Health Profiles, Wisconsin Mortality Records database, Wisconsin Traffic Crash database and others. These sources are footnoted in the respective report and End Notes sections.

I. PREVALENCE

The purpose of this report section is to provide an estimate of the overall prevalence of mental illness and substance abuse, the prevalence or occurrence of selected conditions and consequences, analyze trends, make comparisons with national data where available, and identify disparities among selected target populations. The result will be recommendations regarding needs, gaps and disparities that can later be rated and ranked along with needs, gaps and disparities identified here and elsewhere in this report. This is a logical first step for a needs assessment, that is, describing how many individuals have a mental health or substance abuse need. Measuring the prevalence of needs will help indicate the size of the need and the type of needs that Wisconsin is seeking to address.

Mental Health Prevalence

When mental health professionals assess an individual's mental health condition, it may take several hours of an interview that stretches over a couple of appointments depending on the severity of the individual's condition. Such a process is not possible, of course, when measuring the prevalence of mental health conditions in the entire population. Short phone surveys or personal interviews of a sample are typically used to estimate the mental health condition of the population.

Up to three concepts are typically used in short population mental health measures: clinical symptoms, functional impairment, and duration of the disorder. The National Survey on Drug Use and Health (NSDUH)[2] and the National Comorbidity Study (NCS)[3] are the two major surveys that use this approach to calculate national prevalence estimates of mental health. The frequency of symptoms such as depression, anxiety, stress, and hopelessness are measured. A second set of questions addresses whether the individual believes their symptoms restrict their daily functioning in their job, family, social networks, etc. If both symptoms and functional impairment exist, the individual is estimated to have a "serious mental illness" (SMI). The term for children in this category is severe emotional disorder (SED). Individuals with a mild mental health condition will experience symptoms but still be able to function in their daily life for the most part. Together, these two groups are sometimes called individuals with "any mental illness" (AMI).

The prevalence of mental illness is stated as the percentage of the population who have a SMI or AMI in the past year. While estimates of the prevalence of specific mental health conditions like depression, schizophrenia, bipolar disorder, etc., have been calculated through the use of a more intensive interview process, the SMI/AMI measures are useful for assessing overall prevalence. See Appendix C for more details on the measurement of mental illness in Wisconsin and nationally.

While the prevalence of substance abuse is measured with a fairly standard method regardless of the source, the measurement of mental health prevalence varies depending on the source. Similar to the distinction between AMI and SMI, some measures focus on symptoms only and leave out functional impairment and/or duration of the disorder. In addition, the time frame of assessment varies from one month to one year. Survey question design and survey methodology also vary.

Thus, when selecting a mental health prevalence measure, the purpose of the project and how the prevalence estimate will be used should be considered. Since SMI/SED are common concepts that providers use to assess the level of a consumer's needs and consumers with an SMI/SED are heavily represented in the public mental health system, a mental health prevalence measure that includes SMI/SED was chosen.

Given these criteria, SAMHSA's National Survey on Drug Use and Health (NSDUH) is the most current source of adult mental health prevalence data for both AMI and SMI at both the national and state level. The most recent estimates from the NSDUH (2010-11)[2] indicate an overall national prevalence of AMI at 19.8% and of SMI at 5.0% for adults 18 and older. Wisconsin's specific overall adult rates of AMI and SMI respectively are slightly lower at 19.0% and 4.6%.

Prevalence Rates of Mental Illness in Wisconsin

	Any Mental Illness (AMI)	Serious Mental Illness (SMI/SED)
ADULTS (National)[a]	19.8%	5.0%
ADULTS (Wisconsin) [a]	19.0%	4.6%
CHILDREN (National)[b]	21.0%	11.0%
CHILDREN (Wisconsin)	Not available	Not available

[a] National Survey on Drug Use and Health, 2010-2011.
[b] MECA study.

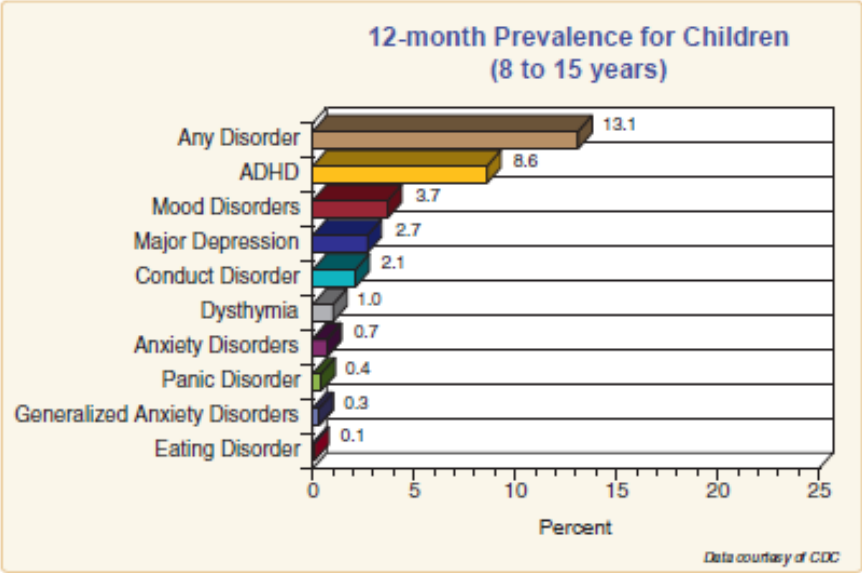
The NSDUH focuses primarily on adults, so estimates of serious emotional disorders (SED) in children are not available. The MECA Study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) has frequently been cited for its estimates of the prevalence of children's mental health disorders including in the U.S. Surgeon General's Report in 2000. MECA Study estimates indicate 21.0% of children experience some form of mental illness within a year and 11.0% experience an SED[4].

Every year, the Wisconsin State Division of Mental Health and Substance Abuse Services (DMHSAS) submits an application for its Mental Health Block Grant to the Substance Abuse and Mental Health Services Administration (SAMHSA). To assist states in assessing their needs, SAMHSA provides prevalence estimates of SMI and SED. SAMHSA's 2011 population estimate of SMI for adults 18 and older is 5.4%[5] and for children is 11.0%[6]. These rates are very similar to the SMI/SED rates from other studies cited above.

Prevalence of Individual Mental Health Disorders

The 2001-2004 National Health and Nutrition Survey (NHANES) survey conducted by the Centers for Disease Control (CDC) provides national estimates of the prevalence of many specific childhood mental health disorders. The most common disorder among 8-15 year olds is attention-deficit/hyperactivity disorder (ADHD), which affects 8.5% of this age group[7]. This is followed by mood disorders at 3.7 percent and major depressive disorder at 2.7 percent.

The National Comorbidity Survey Replication (NCS-R) generates national estimates of the prevalence of specific disorders within a year for adults as displayed in the table below. The category of anxiety disorders is most prevalent among adults at 19% and different types of phobias are the most prevalent specific anxiety disorders occurring in 7-9% of adults[8]. Another way to examine disorders is by severity as illustrated by the rates of serious, moderate, and mild severity in the table below. People with the most serious form of disorders have a greater need for services and usually require more resources to recover. Although phobias are the most prevalent type of anxiety disorder, the percentage of adults who experience them with "serious severity" is the lowest among the anxiety disorders. By contrast, adult separation anxiety disorder is experienced by just 1.9% of adults in a year, but over 50% experience it with "serious severity". Impulse disorders are experienced by 10.5% of adults. While attention deficit-hyperactivity disorder and intermittent explosive disorder are the most prevalent in this category,



oppositional defiant disorder is experienced in its most severe form at almost twice the rate (60.7%) of other impulse disorders. Mood disorders affect 9.7% of adults annually with depression being the most common form.

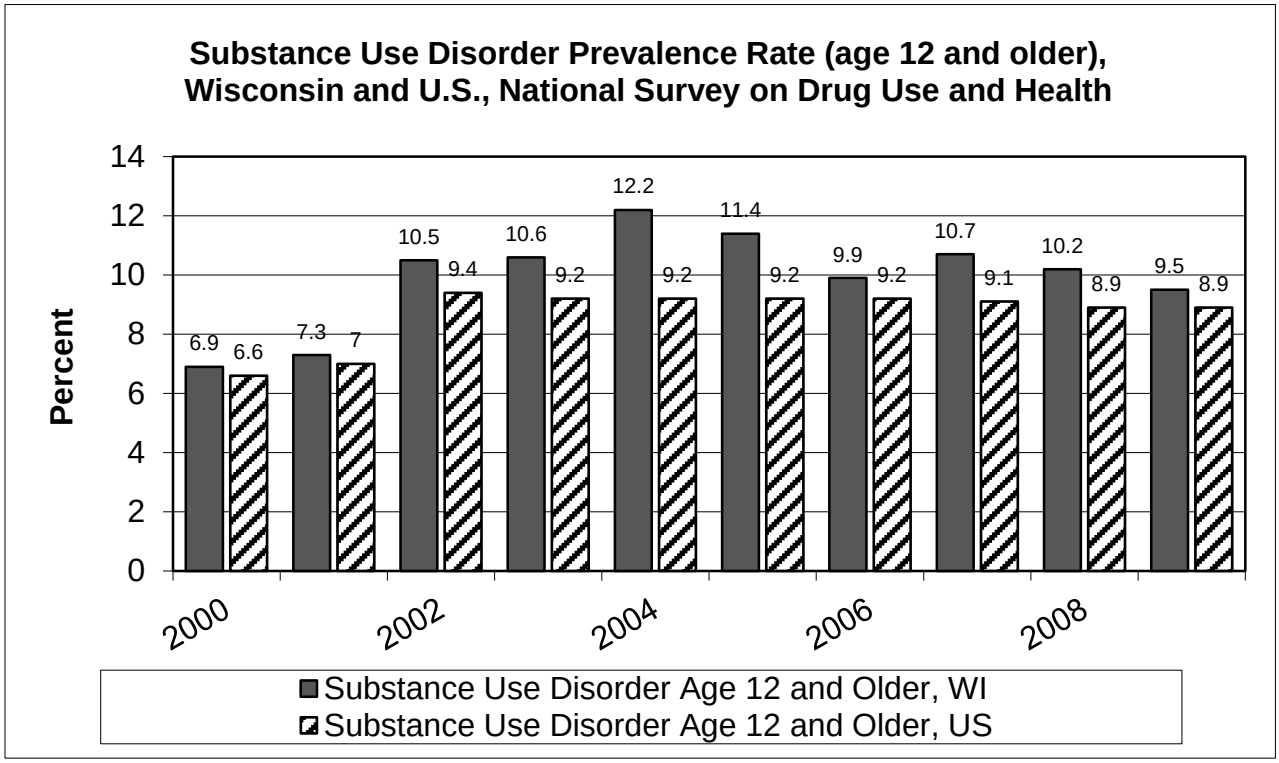
Percentage of Adults with a Behavioral Health Disorder, by Severity (2001-2002)

Disorder by disorder group	12-month prevalence (percent)	Serious severity[1] (percent)	Moderate severity[2] (percent)	Mild severity[3] (percent)
Anxiety disorder				
Panic disorder	2.7	42.6	36.7	20.7
Generalized anxiety disorder	2.7	35.7	46.5	17.7
Social phobia	7.1	37.7	44.5	17.7
Specific phobia	9.1	24.2	38.6	37.2
Agoraphobia without panic	0.9	42.9	36.4	20.7
Posttraumatic stress disorder	3.6	42.7	32.7	24.7
Adult separation anxiety disorder	1.9	51.7	31.6	16.6
Any anxiety disorder	19.0	27.3	40.0	32.6
Mood disorder				
Dysthymia	1.5	55.5	36.0	8.4
Major depressive disorder	6.8	41.5	47.5	11.0
Bipolar disorder	2.8	56.6	38.9	4.5
Any mood disorder	9.7	46.0	44.4	9.6
Impulse disorder				
Oppositional defiant disorder	1.0	60.7	20.0	19.3
Conduct disorder	1.0	34.7	20.1	45.2
Attention deficit hyperactivity disorder	4.1	37.8	26.5	35.8
Intermittent explosive disorder	4.1	32.9	44.6	22.5
Any impulse control disorder	10.5	32.9	36.8	30.3
Substance disorder				
Alcohol abuse	3.1	50.6	16.7	32.7
Alcohol dependence	1.3	98.3	1.7	0.0
Drug abuse	1.3	47.6	18.0	34.5
Drug dependence	0.4	100.0	0.0	0.0
Any substance use disorder	3.8	47.9	18.8	33.3
Any disorder				
Any	26.9	25.5	39.7	34.7
1 disorder	14.2	8.0	38.8	53.2
2 disorders	6.2	26.9	48.5	24.5
3+ disorders	6.6	61.6	33.4	5.0

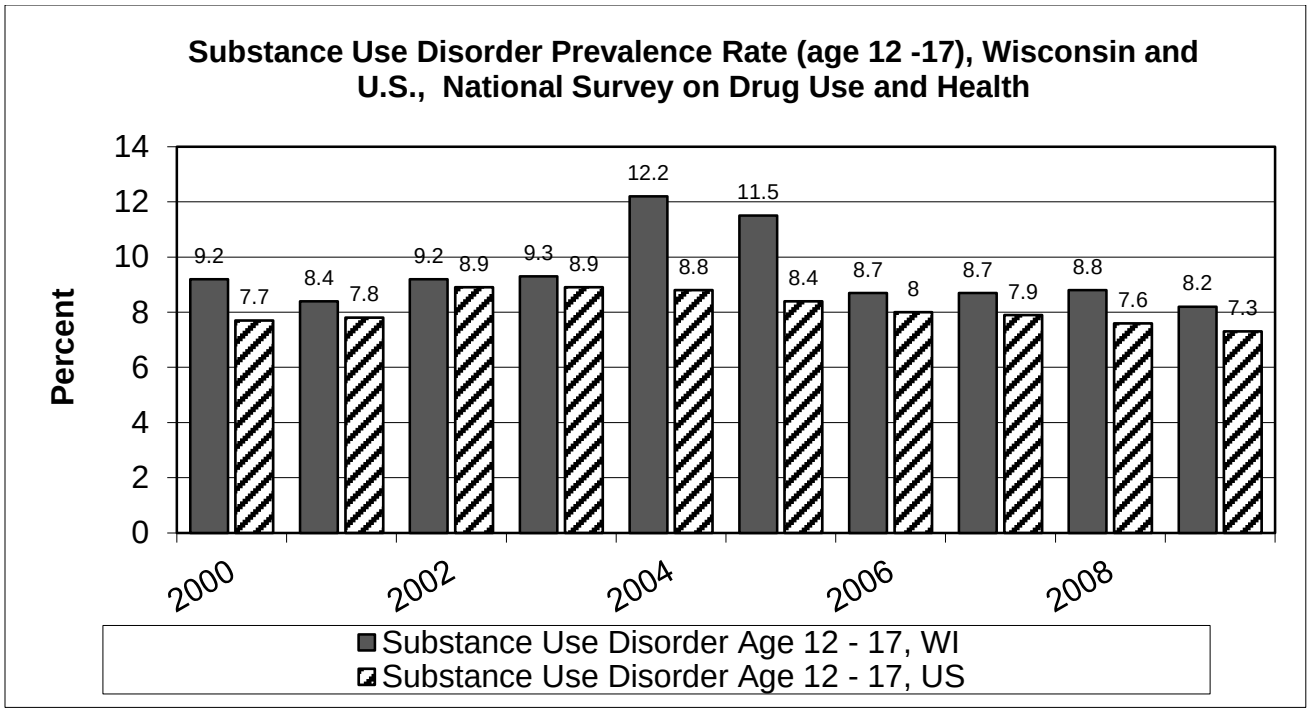
Source: National estimates from the 2001-02 National Comorbidity Survey.

Substance Abuse Prevalence

The 2009-2010 National Survey on Drug Use and Health estimates there are 448,000 (9.5%) persons age 12 and older with a substance use disorder in Wisconsin.[9] A person having a substance use disorder means that he/she meets the screening criteria of a negative pattern of alcohol or other mood-altering drug use resulting in significant health, social, psychological or vocational impairment or distress and where intervention or treatment is warranted. The chart that follows displays ten years of survey data on the overall rate of persons having a substance use disorder in Wisconsin in comparison with the national average. Since 2004, both the Wisconsin and national rates have been declining however Wisconsin exceeds the national rate by half a percentage point. This difference translates to about 28,290 additional Wisconsin persons having a substance abuse disorder compared to the national rate. Trends in the following graph can be misleading due to the calculation confidence intervals for surveys taken from a sample of the population. Confidence intervals give an estimated reliability range above and below the reported statistic (about 3%). For example, a statistic of 7% should be interpreted as being between 4% and 10%.



The next chart portrays the rate of Wisconsin and national substance use disorders among youth age 12 to 17. These rates are also declining since 2004, however, the Wisconsin youth substance abuse prevalence rate is above the national rate adding 3,950 Wisconsin youth substance abusers over the national rate.

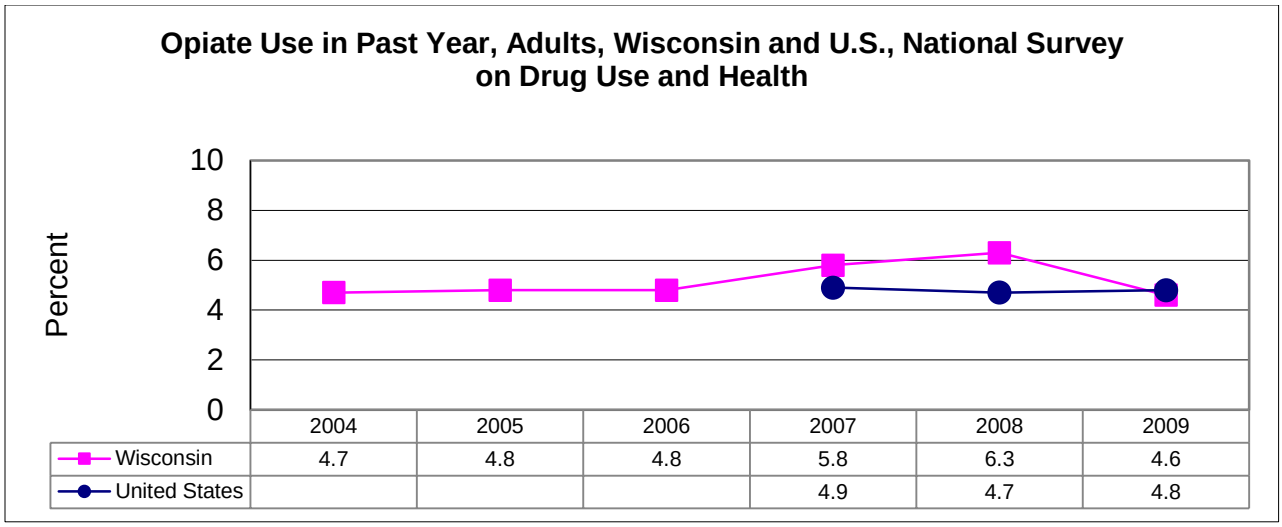


Prevalence of Individual Substance Abuse Disorders and Issues

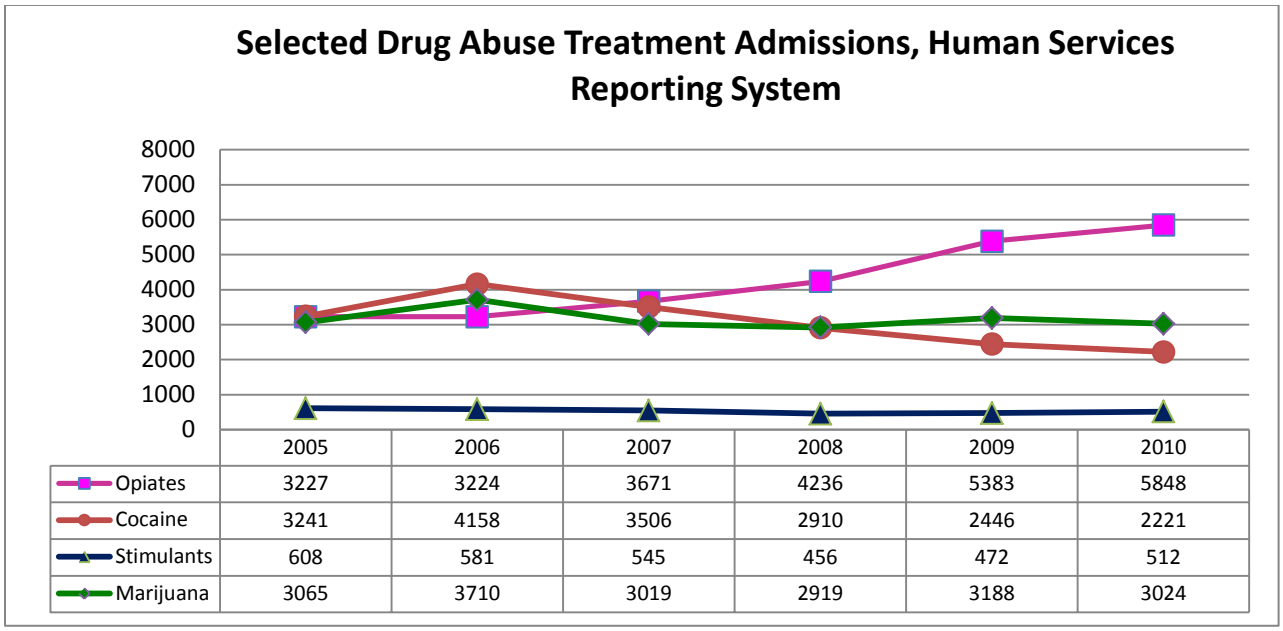
Opiates

Indicators of opiate problems including heroin and the non-medical use of medications like morphine and codeine, have risen recently. Prior to the1980's, opiates topped the list of Wisconsin substance abuse issues giving way to cocaine in the 1980s and methamphetamines in 2000. The resurgence of opiate-related problems causing emergency room visits, crime, homicides, high school drop-outs and loss of employment has public health, criminal justice and policy officials concerned.

While the Wisconsin sample size is small and annual rates may be subject to variations caused by the small samples, the chart below on past year opiate use from the National Survey on Drug Use and Health does not depict a discernible trend in reported nonmedical opiate use in Wisconsin.[9]



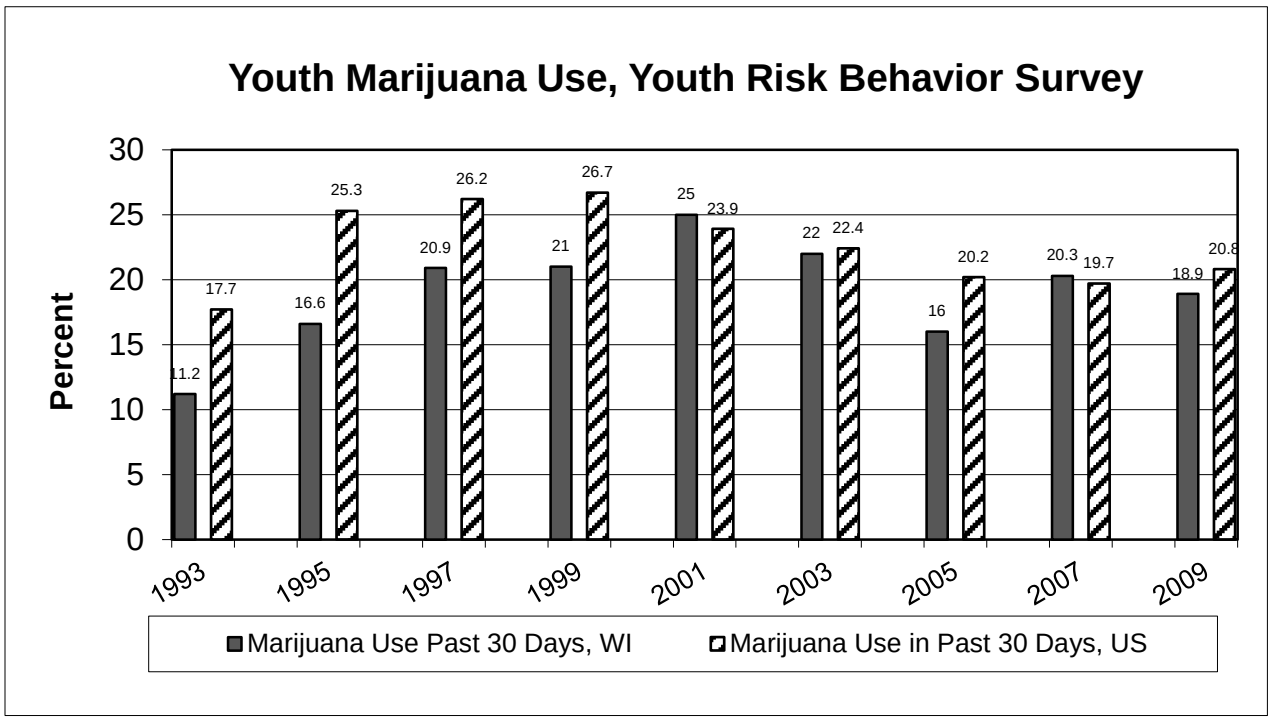
Another indicator of the opiate problem is admissions to treatment. The Human Services Reporting System (HSRS) is Wisconsin's statewide client information database that contains demographic, presenting problems, service and outcome data on clients receiving County-authorized services for substance abuse or mental health needs. This system indicates that there are heroin or other opiate abusers in every County. Depicted in the chart that follows are six-year trends in publicly-supported treatment admissions for three selected drug categories.[10] Opiate admissions are trending upward while cocaine and methamphetamine admissions are down. Data are not yet available from State Medicaid or private health insurance databases.



The minimum annual prevalence of Wisconsin adults needing treatment for heroin or other opiate addiction can be estimated from the National Survey on Drug Use and Health and a 2002 study published in the Human Psychopharmacology journal at 0.8% or 30,450 persons.[9,11]

Marijuana

Commonly called pot, grass, THC, cannabis, weed, hemp or hash, marijuana is a hallucinogenic, habit forming drug which causes impairment in short-term memory, euphoria, increased appetite, intensification of the senses, bloodshot eyes, reduced coordination, dizziness, lowered blood pressure and lethargy. Even small amounts of marijuana can impair cognitive and psychomotor tasks associated with driving.[12] The psychoactive chemical in marijuana, tetra-hydro-cannabinol or Dronabinol, may be useful in the treatment of glaucoma and the nausea caused by cancer medications. In addition to dependence, the effects of long-term marijuana use include depression, indifference, panic attacks, mood swings, paranoia, hallucinations or psychotic reactions, bronchitis, decrease in the production of the male sex hormone testosterone, reduced sperm count, epileptic seizures, impaired memory and judgment, inability to concentrate, apathy, lack of ambition, damage to the body's immune system, miscarriage or infant defects, lung lesions, asthma, lung disease, and irreversible damage to brain cells.[13] In 2010, there were nine (9) Wisconsin deaths attributed to marijuana use. From the Wisconsin Department of Public Instruction's and the Federal Center for Disease Control's Youth Risk Behavior Survey taken every two years, the chart below presents the percent of Wisconsin and U.S. high school youth who report using marijuana at least once in the past 30 days.[14] While Wisconsin teen marijuana use is trending downward in the past ten years and is lower than the national average, 1 in 5 youth report using the substance.



Other Mood-altering Drugs

The non-medical or illicit use of other mood-altering, habit-forming, controlled substances also causes public health and safety issues in Wisconsin. There are essentially 5 categories of these substances: 1) heroin, morphine, codeine narcotic or opiate-based pain relievers; 2) stimulants such as cocaine and methamphetamine; 3) benzodiazepine tranquilizers that relax the muscles; 4)

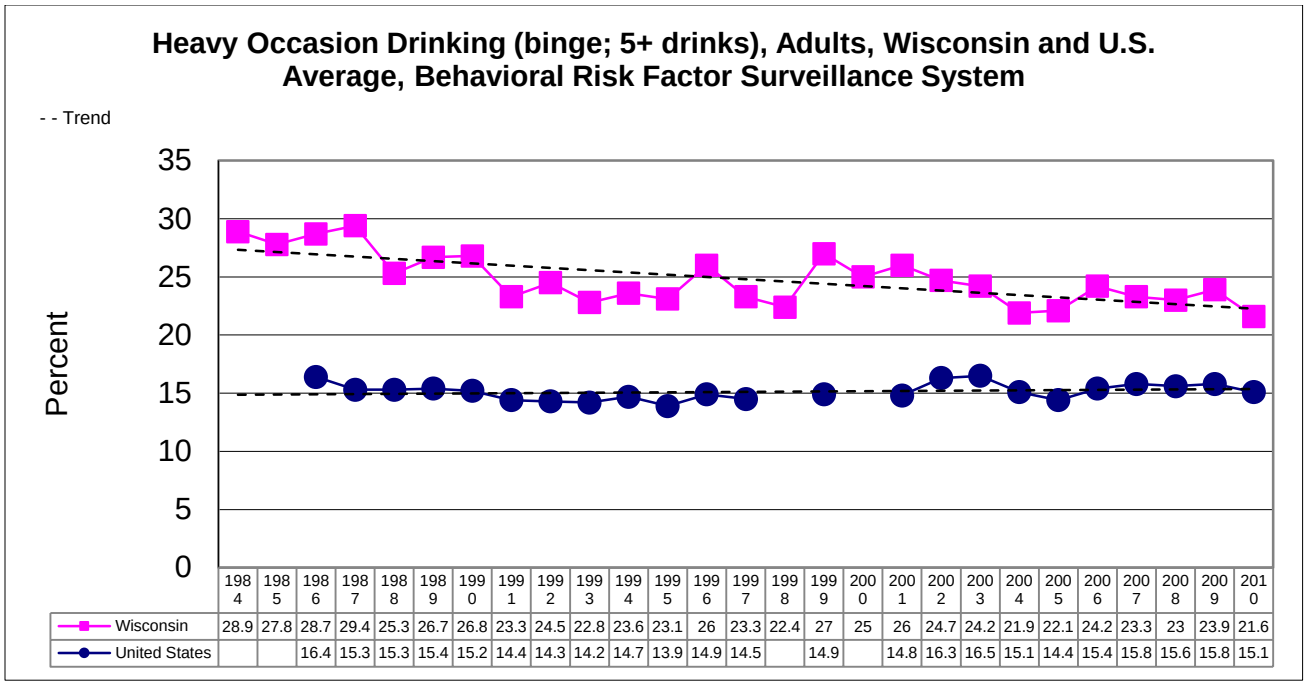
barbiturate sedatives and sleeping pills; and 5) hallucinogens like marijuana, LSD, and PCP. All of these substances are highly addictive and cause significant health and social problems. Opiates, marijuana, and cigarette smoking have been selected for further analysis. The Wisconsin Department of Health Services has a significant role in smoking prevention and Substance Abuse Block Grant funding is tied to reducing sales of cigarettes to minors.

We have received anecdotal reports from stakeholders that synthetic marijuana (K2 or spice) and stimulants (bath salts) are being abused in Wisconsin. They are often sold in legal retail outlets as "herbal incense". The effects of synthetic marijuana can be similar to marijuana and also include agitation, extreme nervousness, nausea, vomiting, tachycardia (fast, racing heartbeat), elevated blood pressure, tremors and seizures, and hallucinations. According to data from the national 2011 Monitoring the Future survey of youth drug-use trends, 11.4 percent of 12th graders used K2 or spice in the past year, making it the second most commonly used illicit drug among high school seniors. Bath salts contain manmade chemicals related to amphetamine stimulants known as cathinones. Similar to the adverse effects of cocaine, LSD and methamphetamine, bath salt use is associated with increased heart rate and blood pressure, extreme paranoia, hallucinations, and violent behavior, which causes users to harm themselves or others. Bath salts use is reported by 1.3% of 12th graders.[114]

Binge Drinking

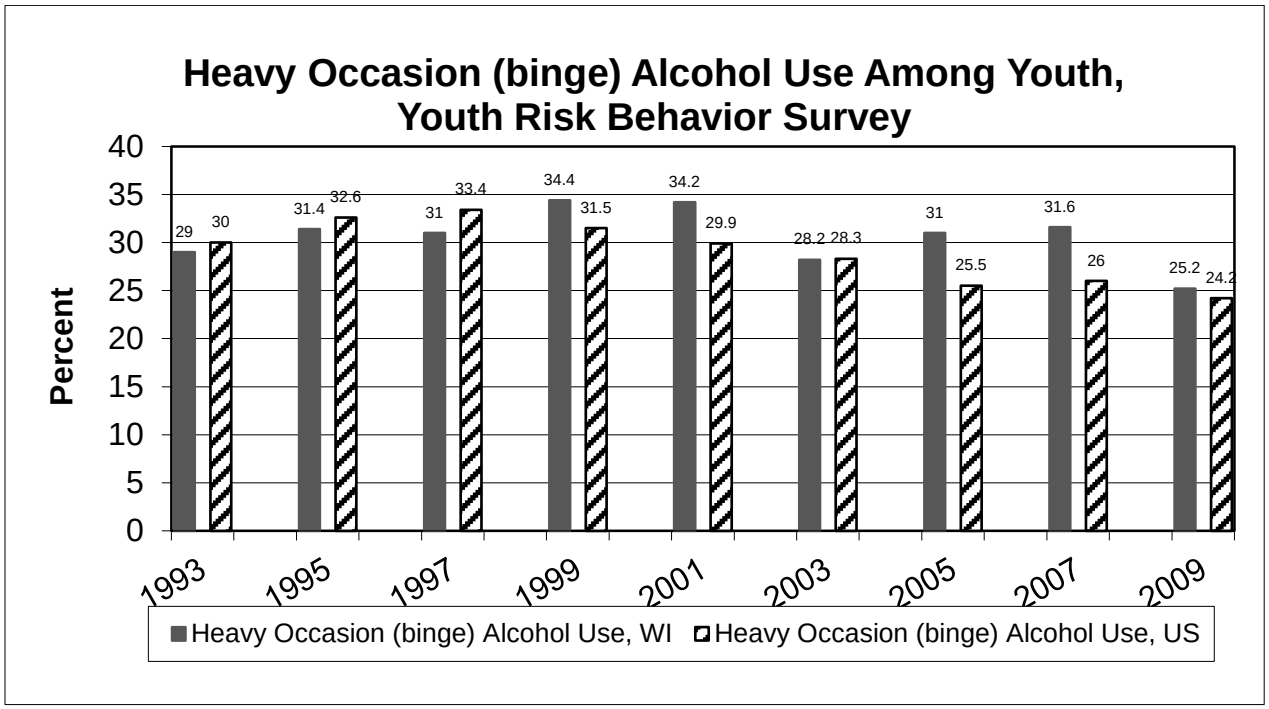
Heavy occasion or binge drinking is another substance abuse issue in Wisconsin we will examine in this needs assessment. Binge drinking for males means having 5 or more drinks on an occasion of drinking; for females it is 4 or more drinks. A male who has 5 drinks in a three-hour period will have a blood alcohol concentration of .05 (.07 within two hours); a female who has 4 drinks in a three-hour period of time will have a BAC of .05 (.08 within two hours). At a BAC of just .02, experiments have demonstrated that people experience some impaired judgment, decreased reaction time, a decline in their visual ability to track a moving object, and a reduced ability to perform two tasks at the same time. At the .05 BAC level, people begin to exhibit more risk-taking behavior, drowsiness, loss of small-muscle control, loss of coordination, more impaired judgment and more impaired reaction time.[15]

The chart below tracks Wisconsin and U.S. adult binge drinking rates over the past 25 years.[16] While Wisconsin's rate of binge drinking in the past month exceeds the national rate by over 6 percentage points, Wisconsin's trend is moving in a positive direction – downward. According to the Wisconsin Behavior Risk Factor Surveillance System survey, in 2010 there were 923,000 Wisconsin adults who reported at least one occasion of binge drinking in the past 30 days. The difference between the Wisconsin and national rate calculates to an additional 278,000 Wisconsin binge drinkers.



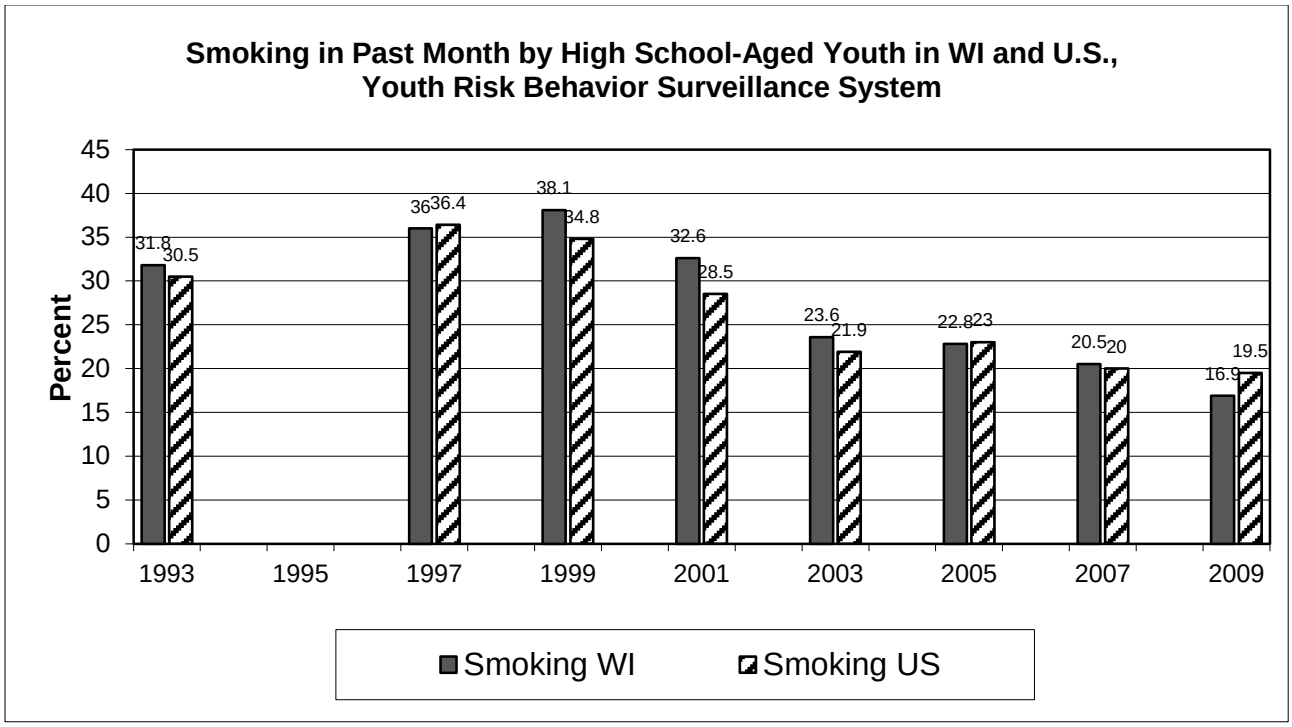
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Wisconsin	28.9	27.8	28.7	29.4	25.3	26.7	26.8	23.3	24.5	22.8	23.6	23.1	26	23.3	22.4	27	25	26	24.7	24.2	21.9	22.1	24.2	23.3	23	23.9	21.6
United States			16.4	15.3	15.3	15.4	15.2	14.4	14.3	14.2	14.7	13.9	14.9	14.5		14.9		14.8	16.3	16.5	15.1	14.4	15.4	15.8	15.6	15.8	15.1

Youth (high school age) binge drinking from the biennial Youth Risk Behavior Survey is displayed in the next chart.[14] Some 73,500 Wisconsin youth reported binge drinking in the past 30 days. The trend is downward since 2001 and in 2009 the difference between the Wisconsin and the U.S. average rate accounts for an additional 3,000 Wisconsin youth who binge drink. Addressing binge drinking among youth is a Wisconsin priority.



Tobacco

According to the Federal Centers for Disease Control, tobacco use is the leading cause of death and disease in the United States, with 443,000 deaths annually attributed to smoking or exposure to secondhand smoke. Nearly all tobacco use begins during youth and young adulthood. One of the conditions of Wisconsin's receipt of Federal substance abuse block grant funds is preventing the sale of cigarettes to underage persons. Called the Federal "Synar Amendment", the Wisconsin Department of Health Services must conduct merchant education activities, cigarette purchase "stings" among merchants, and reduce cigarette purchases by youth to less than 20% during the stings. Wisconsin is subject to a 40% block grant fund penalty if the requirements are not met. In 2011, the national youth purchase rate was 8.5% and Wisconsin's rate was 4.5%, well below the required rate. For these reasons it is important to track cigarette use among youth. In the chart below, we see that cigarette use among Wisconsin youth is trending downward and in 2009 is below the national rate.[14]

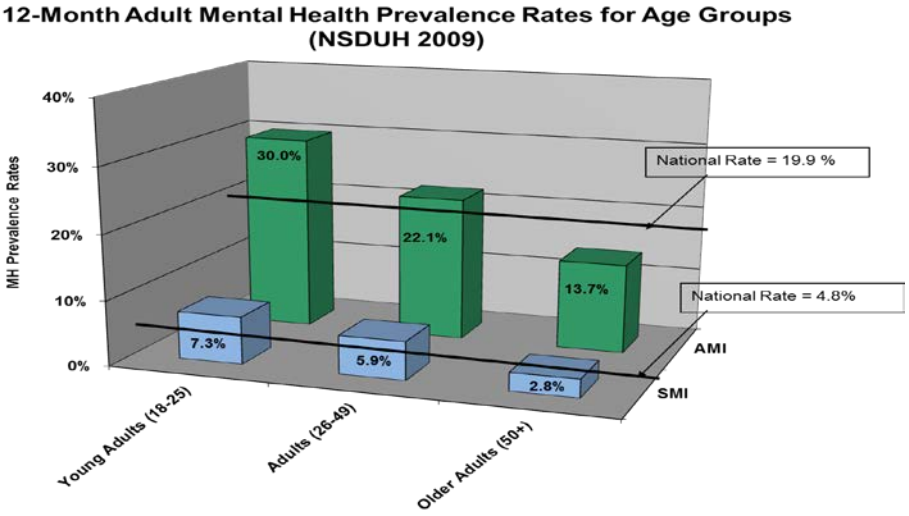


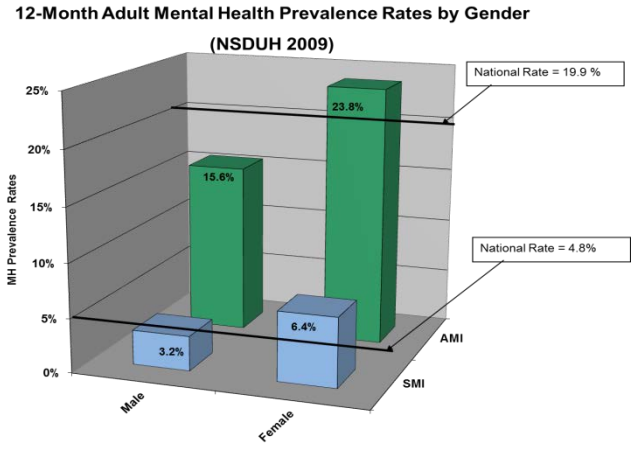
Special Population Groups – Mental Health

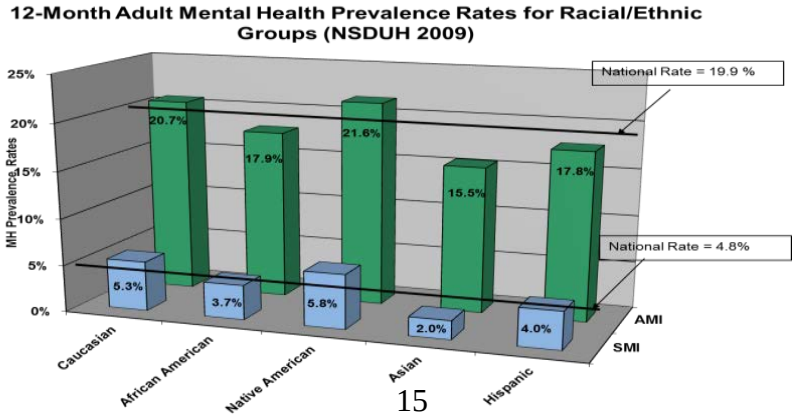
For the purpose of distinguishing groups that may have relatively high mental health needs, the prevalence rates for different demographic and other special population groups are described below. No single data source produces mental health prevalence rates for a large variety of special population groups, but the NSDUH measures prevalence rates for basic demographic groups on a national basis. The national rates are examined here because the NSDUH rates for Wisconsin are not available for all demographic groups.

The 2009 NSDUH results in the charts below describe both prevalence rates for AMI and SMI for a nationally representative sample of adults. Relative to the national 19.9% rate of AMI,

young adults ages 18-25 have significantly higher rates of AMI and older adults rates are significantly lower[2]. Females also have significantly higher rates of AMI than males. When racial and ethnic groups are examined, Native Americans have the highest rate of mental illness, Asians have the lowest, and African Americans and people of Hispanic origin have slightly lower than average rates. The relationship between all of these demographic groups for serious mental illness (SMI) rates is parallel to that of AMI rates.

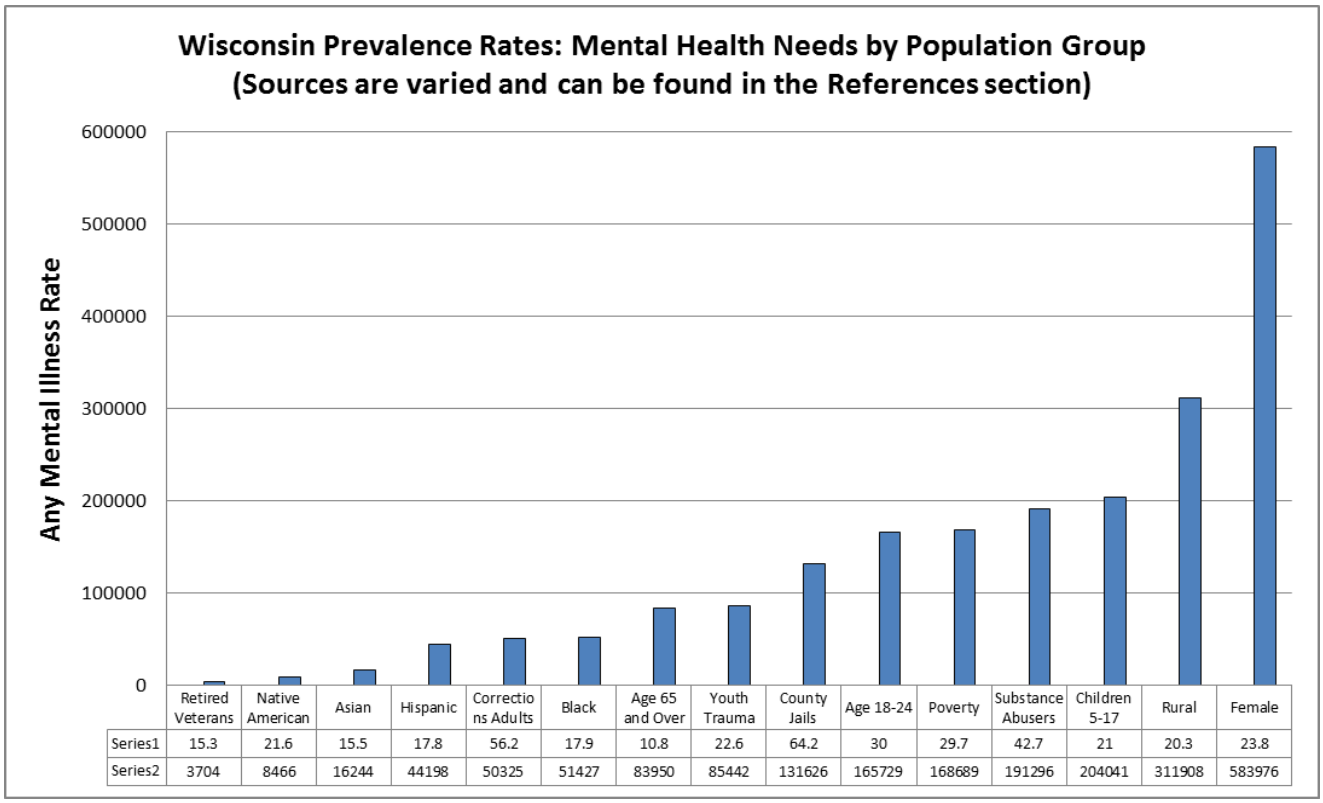






The chart below shows the estimated number of persons in Wisconsin having any mental illness for a variety of selected special populations including the demographic groups described above with the highest rates of mental illness. The prevalence rate (%) within each special population group is also presented in the data table. Where available, the National Survey on Drug Use and Health data were used for the estimates[2] and other sources were used when NSDUH data were not available[17-19]. The prevalence rates were applied to the Wisconsin population 2011 figures. The special populations are listed in ascending order by the estimated number of persons with AMI.

While females and people living in rural areas do not have the highest rate of AMI, they have the highest number of persons with AMI by far because they comprise a large percentage of the state's population. Other groups that have a relatively high number of people with AMI, but also have a higher than average rate of AMI, include young adults aged 18-24 and people in poverty. Populations with the highest rates of AMI include people in State correctional facilities, people in local jails, and people who abuse substances. People who abuse substances not only have a high rate of mental illness (42.7%), but they also comprise the fourth largest special population examined here.



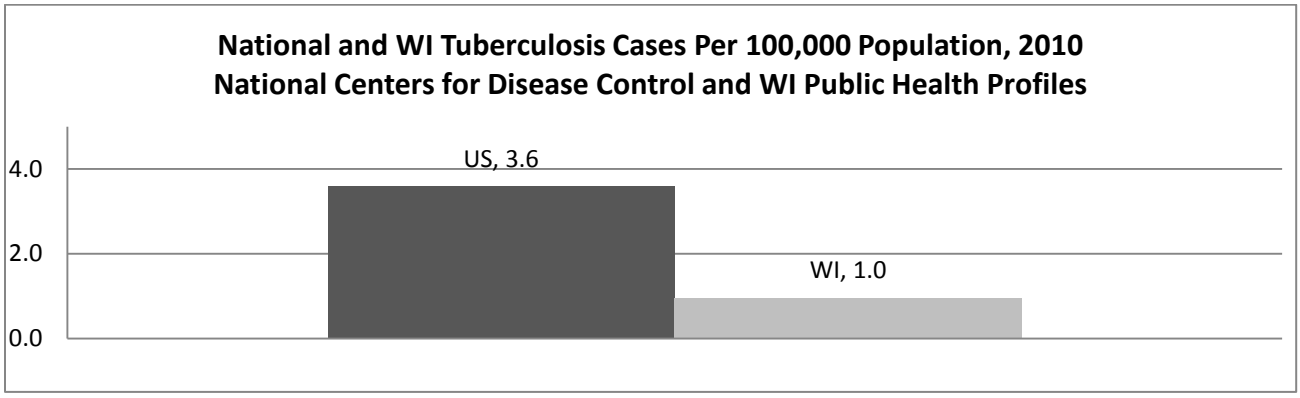
	Retired Veterans	Native American	Asian	Hispanic	Corrections Adults	Black	Age 65 and Over	Youth Trauma	County Jails	Age 18-24	Poverty	Substance Abusers	Children 5-17	Rural	Female
Series1	15.3	21.6	15.5	17.8	56.2	17.9	10.8	22.6	64.2	30	29.7	42.7	21	20.3	23.8
Series2	3704	8466	16244	44198	50325	51427	83950	85442	131626	165729	168689	191296	204041	311908	583976

Special Population Groups – Substance Abuse

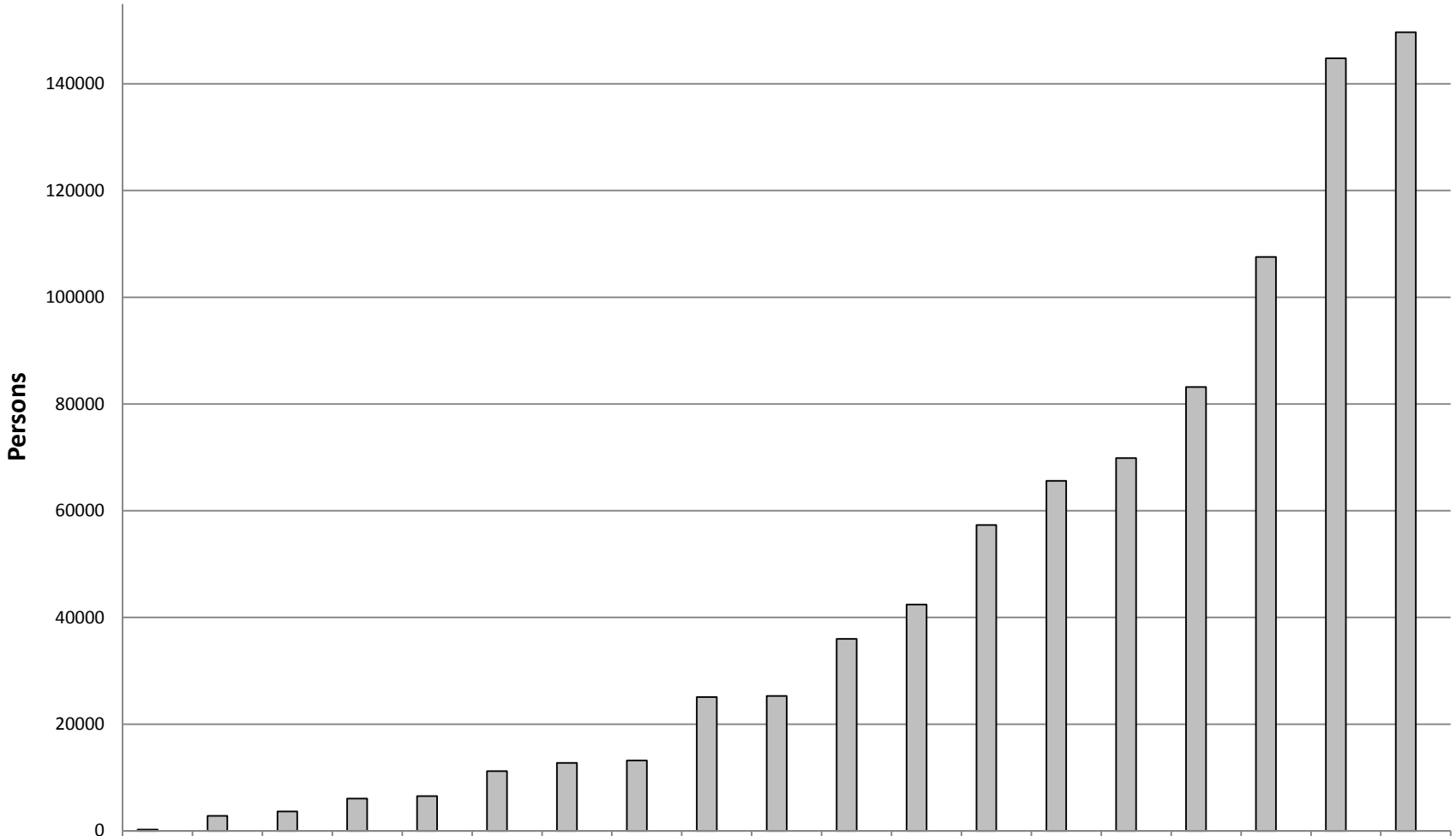
The chart on the next page shows the estimated number of persons having a substance use disorder for each of 19 selected target populations. The prevalence rate (%) or concentration of substance abuse within each special population group is also presented in the data table. Where available, the National Survey on Drug Use and Health was used for the estimate. Other sources include the Department of Defense, Surgeon General, Wisconsin surveys and other studies.[9, 19-32] While the concentration of substance use disorders is highest among corrections, criminal offenders, homeless, returning veterans and LGBT populations, the total number of persons having a substance use disorder among our selected special populations is highest among females, persons having a mental illness, rural populations, persons experiencing severe trauma or trauma-related disorders and persons living in poverty. Other populations such as those who are White, male, living in urban areas and having an alcohol use disorder were not included in the chart because they traditionally make up a large percentage of persons served by Wisconsin's substance abuse services system.

Tuberculosis

Tuberculosis (TB) is an infectious disease that is caused by a bacterium. TB primarily affects the lungs, but it can also adversely affect organs in the central nervous system, lymphatic system, and circulatory system. Active TB is contagious and spread from person to person through airborne particles. If an infected person coughs, sneezes, shouts, or spits, the bacteria can enter the air and come into contact with uninfected people who breathe the bacteria into their lungs. Medications are available to completely eradicate the TB bacterium from the body. TB is a Federal priority. It is important to consider the prevalence of TB in a substance abuse needs assessment analysis because the poor, the homeless, jail inmates, alcoholics, intravenous drug users and health care workers are at higher risk of contracting TB. In 2010, the Federal Centers for Disease Control's National TB Surveillance System showed that Wisconsin's overall rate of TB is much lower than the national rate (see the chart below).[33] About 55 new persons contract TB each year in Wisconsin.



Prevalence Persons: Occurrence of Substance Use Disorders by Population Group
(Sources are varied and can be found in the References section)



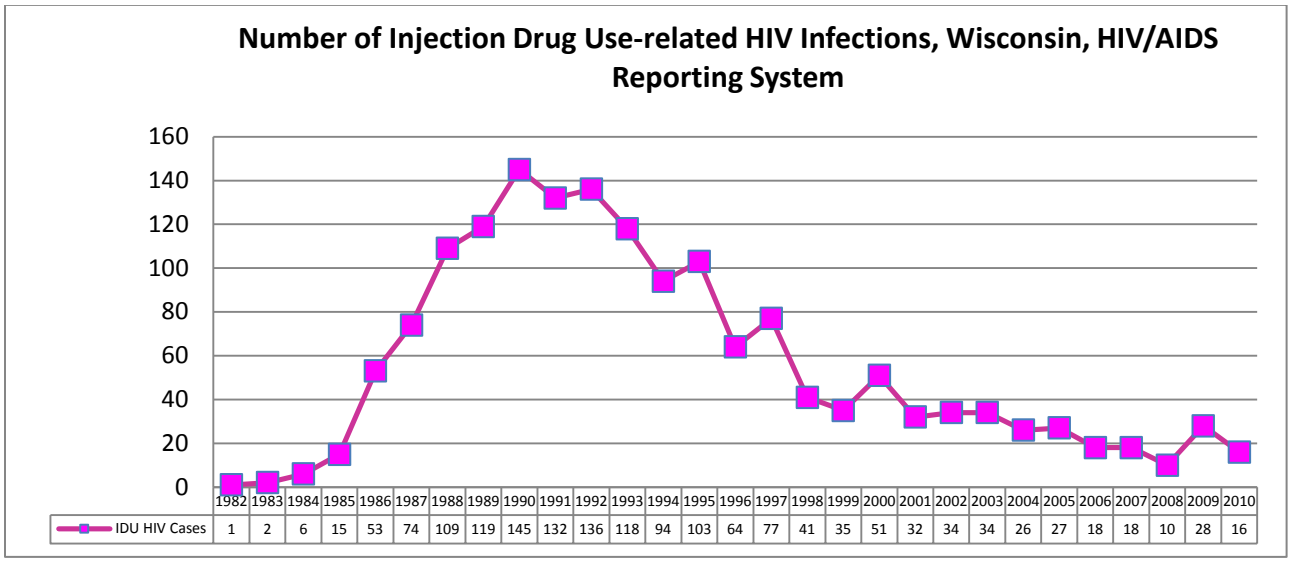
	Corrections Juveniles	Deaf	Asian	Native American	Returning Military	Homeless	Pregnant	Age 65 and Over	Hispanic	Black	Age 12-17	LGBT	Corrections Adults	County Jails	Poverty	Trauma	Rural	Mental Illness	Female
Prevalence Persons	234	2850	3668	6075	6536	11200	12757	13214	25079	25282	36000	42411	57309	65608	69861	83174	107554	144818	149674
Prevalence Rate (%)	43	12	3.5	15.5	27	35	11	1.7	10.1	8.8	8.2	25	64	32	12.3	22	7	13.7	6.1

Hepatitis C

Hepatitis C is a disease caused by a virus that infects the liver. If untreated, it can lead to liver damage including liver cirrhosis, liver cancer, and liver failure. Many people don't know that they have hepatitis C until they already have some liver damage and this can take many years. Some people who get hepatitis C have it for a short time and then get better. Hepatitis C is spread by contact with an infected person's blood such as sharing needles and other equipment used to inject illegal drugs. This is the most common way to get hepatitis C in the United States. In about 15 percent of hepatitis C cases, the body's immune system is able to completely destroy the virus. Building up your immune system and medications to prevent infections are the course of treatment. Although hepatitis C can be very serious, most people can manage the disease and lead full, active lives. The Federal Centers for Disease Control's Viral Hepatitis Statistics and Surveillance Data for 2006-2010 showed a rise in Wisconsin hepatitis C cases from 3 or fewer in 2006 to 10 in 2010.[34] However, the Wisconsin 2010 rate per 100,000 population (0.2) is still lower than the national average of 0.3 cases per 100,000.

HIV

HIV infection is a communicable disease caused by the human immunodeficiency virus (HIV) which damages the body's immune system, the system that fights infections. Without the immune system's protection, the body is defenseless against serious and potentially life-threatening diseases which can lead to the development of Acquired Immune Deficiency Syndrome (AIDS), the later stage of HIV infection. HIV is transmitted through contact with infected body fluids including sharing needles and/or syringes for injecting drugs like heroin with someone who is infected. Early treatment with antiviral and other related medications can slow the progression of HIV disease and the development of AIDS. Because there is no medication that rids HIV from the body, most infected persons will need to take HIV medications their entire lives. HIV infections related to injection drug use are an important indicator of the impact of public health measures and, in part, substance abuse prevention and treatment. The chart that follows presents 30-year trends in new Wisconsin HIV infections related to injecting drugs. Since 1990, the trend has been downward with a leveling off occurring in the last 5 years.[35]



	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
IDU HIV Cases	1	2	6	15	53	74	109	119	145	132	136	118	94	103	64	77	41	35	51	32	34	34	26	27	18	18	10	28	16

Pregnancy and Birth Effects

A University of Wisconsin study[36] found that 3% of pregnant women used mood altering drugs (marijuana, opiates or cocaine) during pregnancy. The National Survey on Drug Use and Health found that 5% of pregnant women in the U.S. reported using marijuana during pregnancy. The University of Wisconsin study also found that 32% of women use alcohol during pregnancy. While fetal *drug* effects are not to be discounted, fetal *alcohol* spectrum disorders are the prominent health issue in Wisconsin. Fetal drug effects are less of an issue because the adverse health and neurobehavioral effects are more temporary (early infancy and early childhood) and not long-term as they are with alcohol.[37] There is a higher risk of stillbirth, miscarriage, low birth weight, painful infant withdrawal, and sudden infant death syndrome with heavy marijuana, opiate or cocaine use. With fetal alcohol syndrome, mental retardation and microcephaly are very permanent effects.

In Wisconsin, 2 of every 1,000 births have fetal alcohol syndrome and an additional 8 of every 1,000 births have alcohol-related neurobehavioral disorders. That translates to 682 births each year that are negatively affected by alcohol. There are an estimated 17,060 persons in Wisconsin between the ages birth to 18 years that have learning disabilities, heart defects, epilepsy, Attention Deficit Hyperactivity Disorder, autism or cerebral palsy related to alcohol-related birth effects. The annual health, special education and human service costs resulting from fetal alcohol spectrum disorders is estimated to be $28,660,800 in Wisconsin.[38]

Pathological Gambling

Pathological gambling is slated to be reclassified alongside other addictive behaviors in the soon-to-be-released psychiatric diagnostic classification system called DSM-5 (Diagnostic and Statistical Manual of Mental Disorders). There are many commonalities between problem gambling and addiction and they are treated using similar methods. And since issues have been raised about this topic from stakeholders, it is important that the issues be discussed in this needs assessment.

Gambling was legalized in Wisconsin beginning with the lottery in 1988. Several greyhound racing parks opened in 1989 and all had shut down by 2010. Tribal compacts for casinos were established in 1991 and 1992. Gambling is a widespread activity and most people gamble responsibly. People who gamble responsibly set and stick to loss, time, and money limits, balance gambling with other leisure activities' limits, do not gamble with household money needed for everyday expenses, do not borrow money in order to gamble and do not gamble when they are stressed. Studies indicate that 1.1% of the adult population has a pathological gambling disorder and an additional 2.8% are problem gamblers all of whom are in need of intervention or treatment. Problem gambling is defined as gambling resulting in a pattern of negative health, financial or social consequences to the gambler, his or her family, employer, or community. Teen rates of problem gambling are higher than for adults. Approximately 4% to 8% of youth between 12 and 17 years of age have a gambling problem and another 10% to 15% are at risk. In Wisconsin there are an estimated 232,525 problem gamblers. The societal costs of problem gambling to Wisconsin are estimated at $10,000 per problem gambler.[110-112]

Since 1993, the Wisconsin Council on Problem Gambling has promoted public awareness and education on problem gambling. The Council staffs a 24-hour helpline (1-800-GAMBLE-5),

hosts an annual conference, conducts two series of gambling counselor professional training, and many other statewide and community activities. The helpline refers callers to local Gamblers Anonymous and Gam-Anon groups, trained counselors, crisis centers, and other community resources. To show the growth of the gambling problem in Wisconsin, calls to the Council's helpline have more than tripled from 3,865 in 1997 to 13,528 in 2011.

Several studies show that approximately 50% of problem gamblers were found to also have drug or alcohol problems. Studies of people in treatment for substance abuse have found between 10% to 30% also have a gambling problem. The problem gambler gets the same effect from gambling as a substance abuser gets from using cocaine or having a drink. The gambling alters the person's mood and the gambler keeps repeating the behavior attempting to achieve that same effect. And just as tolerance develops to drugs or alcohol, the gambler finds that it takes more and more of the gambling experience to achieve the same effect. Gamblers experience "withdrawal" symptoms such as anxiety, irritability and sleeplessness when deprived of gambling.[113]

In 2008, just 15 females and 13 males received problem gambling counseling and were reported in the Human Services Reporting System; 20 females and 12 males were reported in the Medicaid Management Information System. It is unknown how many persons received problem gambling treatment covered by private insurance. Nonetheless, these numbers are unusually low, therefore, access to gambling treatment services is an issue that should be considered.

Geographic Differences – Mental Health

Although county-level measures of mental illness are not available, state and national rates can provide estimates of the number of individuals in counties with mental illness. In the table below, the number of adults and children with AMI and SMI/SED is estimated using the Wisconsin-specific adult rates from the NSDUH (19.0%; 4.6%) and the national children's rates from the MECA Study (21.0%; 11.0%). Since these prevalence rates are not specific to differences among Wisconsin's counties, the figures below are only meant to provide a general approximation.

Wisconsin County-Level Estimates of Individuals with Serious Mental Health Needs Within a Year

County	Estimated Number of Adults w/AMI (19.0%)	Estimated Number of Adults w/SMI (4.6%)	Estimated Number of Children w/AMI (21.0%)	Estimated Number of Children w/SED (11.0%)
Adams	3,300	799	532	278
Ashland	2,362	572	567	297
Barron	6,810	1,649	1,542	808
Bayfield	2,328	564	455	238
Brown	35,980	8,711	9,399	4,923
Buffalo	2,015	488	460	241
Burnett	2,377	576	469	246
Calumet	6,905	1,672	2,061	1,079
Chippewa	9,157	2,217	2,224	1,165
Clark	4,687	1,135	1,520	796
Columbia	8,335	2,018	2,048	1,073
Crawford	2,478	600	579	303
Dane	74,123	17,946	15,918	8,338
Dodge	13,191	3,194	3,021	1,583
Door	4,338	1,050	783	410
Douglas	6,596	1,597	1,430	749
Dunn	6,674	1,616	1,373	719
Eau Claire	15,062	3,647	3,121	1,635
Florence	700	169	122	64
Fond du Lac	15,037	3,640	3,554	1,862
Forest	1,374	333	319	167
Grant	7,700	1,864	1,633	855
Green	5,337	1,292	1,374	720
Green Lake	2,807	680	680	356
Iowa	3,396	822	877	460
Iron	935	226	158	83
Jackson	3,027	733	706	370
Jefferson	12,203	2,954	3,071	1,609
Juneau	4,009	971	873	457
Kenosha	23,730	5,745	6,632	3,474
Kewaunee	3,011	729	757	397
La Crosse	17,357	4,202	3,665	1,920
Lafayette	2,386	578	659	345
Langlade	2,987	723	643	337
Lincoln	4,262	1,032	988	518
Manitowoc	12,014	2,909	2,801	1,467
Marathon	19,360	4,687	5,008	2,623

Wisconsin County-Level Estimates of Individuals with Serious Mental Health Needs Within a Year (continued)

County	Estimated Number of Adults w/AMI (19.0%)	Estimated Number of Adults w/SMI (4.6%)	Estimated Number of Children w/AMI (21.0%)	Estimated Number of Children w/SED (11.0%)
Marinette	6,345	1,536	1,324	693
Marquette	2,350	569	486	255
Menominee	551	133	206	108
Milwaukee	135,895	32,901	34,969	18,317
Monroe	6,352	1,538	1,764	924
Oconto	5,556	1,345	1,297	679
Oneida	5,578	1,350	1,008	528
Outagamie	25,463	6,165	6,800	3,562
Ozaukee	12,677	3,069	3,241	1,698
Pepin	1,086	263	259	136
Pierce	6,073	1,470	1,380	723
Polk	6,424	1,555	1,600	838
Portage	10,600	2,566	2,192	1,148
Price	2,163	524	426	223
Racine	28,017	6,783	7,414	3,883
Richland	2,629	637	632	331
Rock	22,955	5,558	6,110	3,200
Rusk	2,166	524	506	265
St. Croix	11,805	2,858	3,537	1,853
Sauk	9,038	2,188	2,270	1,189
Sawyer	2,504	606	517	271
Shawano	6,176	1,495	1,463	766
Sheboygan	16,727	4,050	4,230	2,216
Taylor	2,974	720	768	402
Trempealeau	4,189	1,014	1,057	554
Vernon	4,206	1,018	1,199	628
Vilas	3,367	815	581	304
Walworth	15,075	3,650	3,690	1,933
Washburn	2,424	587	488	255
Washington	19,113	4,627	5,034	2,637
Waukesha	56,794	13,750	14,940	7,826
Waupaca	7,793	1,887	1,836	962
Waushara	3,758	910	761	399
Winnebago	25,054	6,066	5,459	2,860
Wood	11,026	2,669	2,573	1,348
Wisconsin Total	**833,256**	**201,736**	**204,041**	**106,879**

Geographic Differences – Substance Abuse

Do significant geographic differences exist in the overall prevalence of substance abuse in Wisconsin? Since survey sample sizes are generally too small (and cost-prohibitive) to accurately estimate the prevalence of substance abuse at the County level, to answer this question we must draw on data from several related substance abuse indicators studies. A University of Wisconsin study[39] found that the estimated rate of substance abuse prevalence among Counties ranged from 7.7% (Washington County) to 13.3% (Waupaca County). The spread is about half the overall Wisconsin prevalence rate indicating that there are meaningful differences in substance abuse prevalence and prevalence rates among Counties. The average prevalence rate among large urban Counties (i.e., Milwaukee, Dane, Waukesha, Brown, Racine, Rock, Winnebago, Outagamie and Kenosha) did not differ from the overall state prevalence rate. Small rural Counties (i.e., Adams, Ashland, Buffalo, Burnett, Crawford, Florence, Iron, Jackson, Lafayette, Marquette, Pepin, Price, Rusk, Sawyer and Washburn) averaged about a percentage point above the state prevalence rate.

Another University of Wisconsin study[40] analyzed geographic differences among substance abuse indicator rates such as drug and OWI arrests, liquor law violations, alcohol and drug-related hospitalizations and alcohol-related deaths and found Washington County at about the state average and Waupaca County below the state average. Most large urban Counties were above the state average and two-thirds of the small rural Counties were below the state average. When looking at only alcohol-related indicator rates such as traffic crashes and fatalities, liquor licenses, and other alcohol deaths, the study found Washington County below the state average and Waupaca County above the state average. On the alcohol-only indicators, the large urban Counties were all below the state average, however, 85 percent of the small rural Counties were above the state average.

The number and density of bars, taverns and liquor stores in communities has been shown to correlate with alcohol-related problems such as assault, traffic crashes, injury, suicide and child abuse.[41-50] Communities with higher concentrations of alcohol outlets (per capita) have higher concentrations of alcohol-related problems. The table on the next page, prepared by the Wisconsin Office of Health Informatics and University of Wisconsin Population Health Institute, shows Wisconsin county-level information about the number of alcohol sales licenses in relation to the number of people in the county. Counties with alcohol sales license densities well above the state average include Ashland, Bayfield, Buffalo, Burnett, Door, Florence, Forest, Iron, Menominee, Oneida, Pepin, Price, Rusk, Sauk, Vilas and Washburn.

Alcohol License Density by County, Wisconsin, 2011-2012[51]

County	2011 Population	2011-2012 Licenses Issued	Licenses per 500 Population
Adams	20,935	100	2.4
Ashland	16,064	115	3.6
Barron	45,925	163	1.8
Bayfield	15,036	150	5.0
Brown	249,192	662	1.3
Buffalo	13,620	84	3.1
Burnett	15,448	97	3.1
Calumet	49,109	128	1.3
Chippewa	62,610	228	1.8
Clark	34,719	141	2.0
Columbia	56,850	179	1.6
Crawford	16,600	96	2.9
Dane	489,331	1,110	1.1
Dodge	88,789	277	1.6
Door	27,765	248	4.5
Douglas	44,176	210	2.4
Dunn	43,787	109	1.2
Eau Claire	99,012	241	1.2
Florence	4,337	43	5.0
Fond du Lac	101,740	307	1.5
Forest	9,180	83	4.5
Grant	51,280	202	2.0
Green	36,884	108	1.5
Green Lake	19,091	89	2.3
Iowa	23,720	101	2.1
Iron	5,828	89	7.6
Jackson	20,475	99	2.4
Jefferson	83,794	277	1.7
Juneau	26,725	136	2.5
Kenosha	166,632	400	1.2
Kewaunee	20,594	104	2.5
La Crosse	114,919	324	1.4
Lafayette	16,880	81	2.4
Langlade	19,901	116	2.9
Lincoln	28,668	154	2.7
Manitowoc	81,406	288	1.8
Marathon	134,414	410	1.5
Marinette	41,719	227	2.7
Marquette	15,392	71	2.3
Menominee	4,202	27	3.2
Milwaukee	948,369	1,960	1.0
Monroe	44,877	132	1.5
Oconto	37,723	196	2.6
Oneida	35,962	259	3.6
Outagamie	177,455	491	1.4
Ozaukee	86,530	215	1.2
Pepin	7,461	47	3.1
Pierce	41,085	121	1.5
Polk	44,244	159	1.8
Portage	70,370	227	1.6
Price	14,000	102	3.6
Racine	195,225	504	1.3
Richland	18,045	54	1.5
Rock	160,287	326	1.0
Rusk	14,703	90	3.1
St. Croix	61,951	277	2.2
Sauk	16,600	201	6.1
Sawyer	41,954	228	2.7
Shawano	115,569	369	1.6
Sheboygan	84,503	198	1.2
Taylor	20,681	99	2.4
Trempealeau	28,905	137	2.4
Vernon	29,849	102	1.7
Vilas	21,444	240	5.6
Walworth	102,485	334	1.6
Washburn	15,900	100	3.1
Washington	132,206	322	1.2
Waukesha	390,267	760	1.0
Waupaca	52,392	214	2.0
Waushara	24,531	102	2.1
Winnebago	167,245	426	1.3
Wood	74,669	232	1.6
Wisconsin	**5,694,236**	**17,298**	**1.5**

II. ACCESS TO SERVICES

The purpose of the analysis in this report section is to examine available data on prevention and treatment service access issues. Areas that will be analyzed include geographic access issues, the penetration rate or "treated prevalence", reasons people do not seek or obtain needed services, waiting lists and disparities among selected target populations. Comparisons with national data will be made where available.

Access to services can be defined in different ways with subtle variations. "Access" may refer to whether or not someone is enrolled into a service system to receive help for a mental health or substance abuse need. Many potential barriers lay in the path of someone accessing the help they need including:

- meeting eligibility requirements
- adequate financial resources
- insurance coverage policies
- personal motivation – self-awareness of one's own needs
- availability of services in the geographic area
- capacity of the local service system

One or more of these barriers can prevent an individual from being officially enrolled into a service agency – the first step to receiving services. Even when an individual is enrolled into services, secondary problems with access to services may still occur such as staff availability (to be discussed later). However, usually the first issue in assessing access to services is how many individuals with needs actually were enrolled into services.

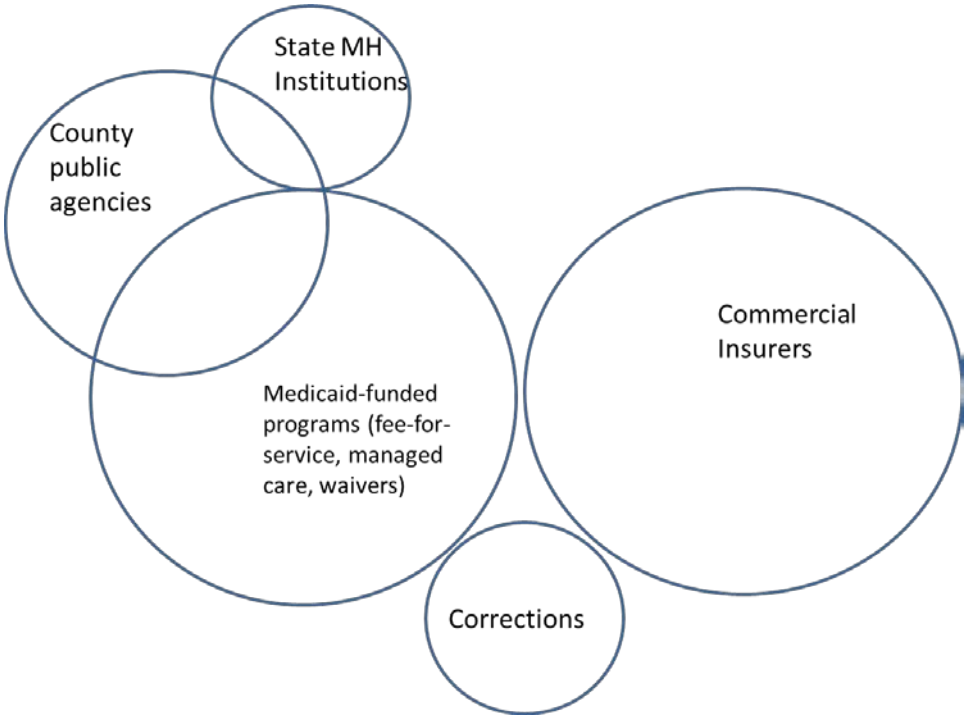
Number of Mental Health Consumers Served

The number of consumers served is sometimes referred to as "treated prevalence". Treated prevalence can be defined as the percentage of individuals with needs who actually received mental health services. The untreated prevalence describes the gap between the population's need (as described in the "Prevalence" section of this report) and whom the service system is currently treating.

The number served includes individuals served in both the public and private systems. Mental health consumers are treated through a variety of different programs and service systems. The diagram below illustrates a majority of those programs and service systems including the Medicaid program and commercial insurance companies which fund most of the mental health services provided in Wisconsin. Using data from all of these sectors, the following analysis attempts to count the total number of consumers receiving mental health services across the state. Consumers could possibly receive services from any combination of service sectors. However, the diagram simply illustrates which programs or service sectors are included in the following analysis and how consumers were unduplicated across sectors. Overlapping sectors represent service recipients that were unduplicated.

The public system is defined as both services provided by public agencies and services paid for with public funds. The primary providers of public services are Wisconsin's 67 county-based mental health agencies who report all consumers served to the State Department of Health services through the Human Services Reporting System (HSRS). In 2011, these agencies served 73,636 mental health consumers. Of these consumers, 87% were adults aged 18 and over.

Mental Health Programs and Service Sectors with Data on Consumers Served



Consumers with a serious mental illness (SMI) or serious emotional disorder (SED) made up 50% of those served in the public county system.

The State of Wisconsin provides public services through the Mendota and Winnebago Mental Health Institutes. The two institutes had 2,065 residents throughout 2011. Most of these (82%) are consumers already reported by counties through the state HSRS data system. The counties and the two state institutes served a total of 74,008 mental health consumers in 2011. Of all the consumers served in these components of the public mental health system, 2.8% were a resident at a state institute at some point in 2011.

County mental health providers use county tax levy dollars to fund a portion of the services they deliver. State and federal tax dollars are also used to fund a portion of mental health services for public consumers. The largest source of federal funds for the provision of MH services is through the Medicaid program. Mental health consumers were identified in the Medicaid fee-for-service and managed care data based on having a primary diagnosis for mental health needs. The largest number of mental health Medicaid recipients are served through the managed care programs as described in the table below. While 111,081 consumers were served through the fee-for-service program, another 127,030 were served through the Medicaid managed care programs. Since a consumer's Medicaid status may change throughout the period of a year and program coverage policies have limitations, some consumers may use benefits through both programs to get the services they need. Of consumers in the managed care programs in 2011, 8.5% also received some fee-for-service benefits and they were unduplicated from the total for the analysis.

Two other smaller Medicaid managed care programs that are reported through different data systems include the Milwaukee Wraparound and the Dane County Children Come First (CCF) programs whom serve children with SED. These two programs served 1,409 children in 2011. The Children's SED waiver program is managed by the State Division of Long-Term Care and targets children with serious mental health needs who also have a developmental or physical disability. In 2011, 1,386 children were served through this mental health program.

After unduplicating consumers who received services through multiple programs, a total of 220,737 consumers received mental health services through Medicaid programs in 2011. Because some Medicaid beneficiaries receive their services through the public mental health system, overlap with the consumers reported through this system needed to be eliminated also. Of those served in the county public mental health system in 2011, 34% used Medicaid as one of their payers and were thus unduplicated from the analysis. As a result, data reported from a majority of the public service sector including people using public Medicaid funds indicate a total of 257,999 consumers received mental health services in 2011.

Mental Health Consumers Served through Different Programs and Service Systems in 2011

Wisconsin Programs/ Agencies Providing Mental Health Services	2011 Adults Served	2011 Children Served	2011 Total Served
County Public System	64,104	9,532	73,636
Two State MH institutions	1,654	411	2,065
MA Fee-for-Service	84,073	27,008	111,081
MA Managed Care	79,655	47,377	127,030
MA Milwaukee Wraparound/ Dane CCF	0	1,409	1,409
MA Children's Long-Term Care SED Waiver	0	1,386	1,386
Unduplicated Subtotal	**186,210**	**71,789**	**257,999**
Corrections	10,400	522	10,922
Commercial Insurers[a]	219,501	38,313	257,814
Total Consumers Served (partially unduplicated)[b]	416,111	110,624	526,735

[a] Commercial insurance clients estimated based on 75% of data and includes some clients with developmental disabilities that could not be removed.
[b] The total number of people served is unduplicated across the county system, institutions, and Medicaid-funded services. However, some duplication of clients served through other providers may exist.

The State Correctional system also provides mental health services to some of its residents. Although it does not keep detailed records of the types and amounts of mental health services provided to clients, the Correctional system does track the number of clients receiving psychiatric evaluations, medication, or therapy. In the adult correctional facilities across the state, State Corrections officials reported approximately 7,800 clients received mental health services at any one point throughout 2012. Officials estimated an annual turnover rate in their mental health caseload of one-third which was used to calculate an estimated 10,400 adults receiving mental health services in the correctional system annually. In the two juvenile correctional facilities in Wisconsin, officials were able to identify the exact total number of youth receiving a psychiatric evaluation and/or mental health therapy in the 12 months prior to November 29, 2012. Of the 662 males and 72 females residing in these two facilities during this period, 450 males and all 72 females received one of these mental health services.

The private system is defined as mental health services provided by private agencies through the use of private funds primarily from individuals and insurance plans. While insurance companies keep detailed records of services provided to clients subscribed to their coverage plans, calculating a statewide total of service recipients has been difficult historically due to the decentralized storage of these records across multiple insurance companies. However, the Wisconsin Health Information Organization (WHIO), formed in 2007, has built a collaboration of health care agencies, including commercial insurance companies, aimed at addressing this information gap. WHIO has collected agreements from public and private health care providers and funders willing to contribute their client data to a central database. WHIO manages the centralized database which includes data on an estimated 68% of Wisconsin's population as of

December 2012 including Medicaid recipients reported through the Department of Health Services.

WHIO's data helps estimate the elusive number of people accessing mental health services through different commercial insurance plans across the state. Current available data includes an estimated 75% of all commercially-insured clients in Wisconsin. Based on WHIO's existing database, an estimated 257,814 consumers accessed mental health services in 2011 through the following commercial insurance plans:

- The Alliance
- Anthem BCBS
- DeanCare
- GHC - South Central Wisconsin
- Gunderson Lutheran Health Plan
- Health Tradition Health Plan
- Humana
- MercyCare
- Network Health Plan
- Physicians Plus
- Security Health Plan
- United HealthCare
- Unity
- WPS
- WEA

Although the data may only represent 75% of clients receiving mental health services through commercial insurance in 2011, the numbers also include clients with developmental disabilities that could not be removed for this analysis. Some commercial insurance clients may also switch to Medicaid insurance or be served in the county public system within a year, but such clients could not be unduplicated for this analysis. Other groups of clients not included are consumers served through other sectors such as Child Welfare and Long-Term Care programs like Family Care. However, many of the Child Welfare clients would be expected to be referred and treated in programs already included in this analysis and the number of Family Care clients would be small relative to the other groups of clients reported. A final caveat is that no information on people who self-pay was included.

Mental Health Treatment Gaps

In the Prevalence section of this report, 1,037,297 people in Wisconsin were estimated to have any type of mental illness (AMI) in 2011: 833,256 adults and 204,041 children. Based on the above statistics, 526,735 people in Wisconsin were estimated to have received some type of mental health treatment in 2011: 416,111 adults and 110,624 children. The difference is the estimated number of people with mental health needs who did not access treatment in Wisconsin, or the estimated "treatment gap". Estimates indicate that 49% (510,562) of people with any mental illness in Wisconsin in 2011 did not access treatment. Among adults, 50% (417,145) did not access treatment. Among children, 46% (93,417) did not access treatment.

A 2007 national estimate based on survey data from the National Survey on Drug Use and Health (NSDUH) found 55% of adults who experienced serious psychological distress (SPD) did not receive mental health services in the past year[52]. A 2009 NSDUH estimate indicated a high proportion of adults with AMI (62%) or SMI (40%) did not receive any mental health services[53]. Based on these estimates, Wisconsin's mental health treatment gap is narrower than the national average.

Number of Substance Abuse Consumers Served and Gaps

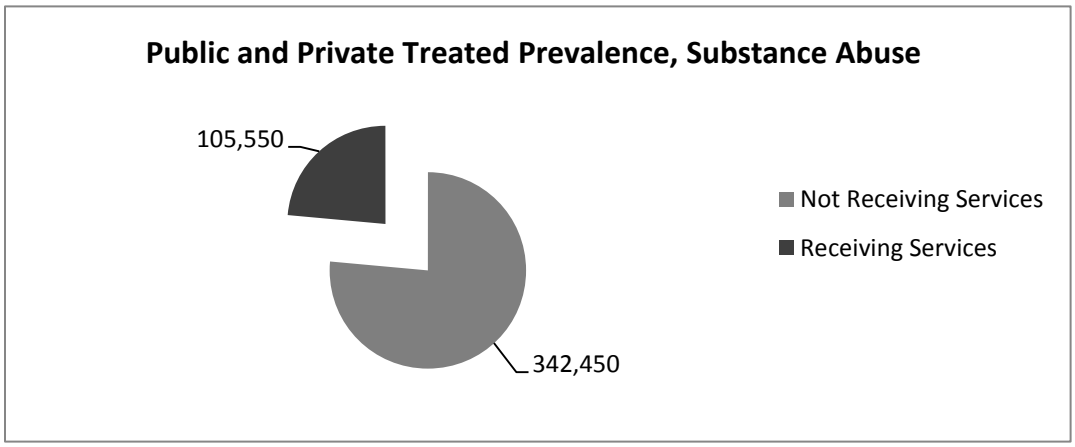
Switching now to substance abuse treatment access issues, how many persons who need treatment get treatment? The 2010 National Survey of Substance Abuse Treatment Services – Wisconsin sample, found that there were 306 persons in treatment on any given day per 100,000 population or a total of 17,385 persons.[54] The national average across states is 381 persons in treatment per 100,000 population indicating that Wisconsin's rate of treatment is 20% below the national average in this study.

The 2010 National Survey on Drug Use and Health - Wisconsin sample, provides an estimate of the rate and number of persons needing but not receiving substance abuse treatment.[9] According to the survey, 448,000 youth and adults needed treatment in Wisconsin that year but only 8% or 36,000 persons received treatment. For youth, the percentage receiving treatment is 3% or 1,100 persons. Since these data are considered low-end estimates, it will be necessary to conduct further analyses (described below) to arrive at a more accurate annual treated prevalence.

An analysis of Wisconsin Human Services Reporting System (HSRS; County-authorized and subsidized treatment), standard Medicaid and private insurance data will provide the best picture of the treated prevalence in Wisconsin. The analysis is presented in the table that follows.

	HSRS	**Medicaid**	**Overlap of clients between HSRS and Medicaid**	**Total Number of Persons Served with Public Support**
Unduplicated Persons Receiving Substance Abuse Services, 2010	48,100	11,800	5% or 2,900 persons	57,000

It should be noted that substance abuse service data from private insurers is not included in the above table and so the 57,000 persons served in a year is incomplete. Based upon survey data showing that about 46% of persons receiving services have private health insurance or self-pay[9], the grand total number of persons receiving treatment in Wisconsin in 2010 could approach 105,550. This 105,550 figure is corroborated by data obtained from an analyst at The Alliance, Fitchburg, WI. The analyst used 2011 data from one of Wisconsin's largest health information exchanges owned by the Wisconsin Health Information Organization (WHIO). WHIO's database covers over 85% of Wisconsin's private-insured residents. The analyst identified 36,050 persons receiving substance abuse treatment paid for with private insurance. Adjusting for the 85% coverage rate, a revised estimate of treated prevalence would be very close at 99,410. The grand total number of persons receiving substance abuse services each year is estimated to be between 99,410 and 105,550. Using the upper end figure of 105,550 persons receiving treatment each year, Wisconsin's treated penetration rate would be estimated at 105,550/448,000 or 23% (see chart below).



Each year the Division of Mental Health and Substance Abuse Services gathers data from County agencies administering or providing substance abuse services.[55] Data on waiting lists and unavailable services are collected. In 2010, 395 persons statewide were denied a needed service such as residential, intensive outpatient counseling or narcotic treatment due to lack of availability or lack of public funding. An additional 2,460 persons statewide were placed on a waiting list for services such as residential, intensive outpatient counseling, regular outpatient counseling or narcotic treatment where they were required to wait two to three weeks before receiving services. Studies show that clients from waiting lists are at higher risk of not starting treatment or withdrawing from treatment.[56,57] Thirty-five (35) County agencies identified services that were needed but not available. Eighteen (18) Counties indicated that residential or housing services were insufficient; 14 Counties identified insufficient clinical staff for outpatient counseling; and 6 identified insufficient narcotic treatment services.

Geographic Disparities in Access to Mental Health Treatment

Examining disparities in access to treatment by county is a logical place to start since Wisconsin is a county-based service system. However, the calculation of treated prevalence for the state did not include county-level data. Although county-level treated prevalence data may be available for most of the sectors identified, obtaining permissions and agreements from other agencies for county-level data was not possible for this report. However, county-level data is readily available describing publicly-funded consumers - consumers using Medicaid and consumers served through the county public mental health system. While all providers are bound by State statutes and administrative rules, most of the State DHS's influence is over the publicly-funded consumers via policies, grant funding, and training and technical assistance. Thus, examining the treated prevalence by county for only publicly-funded consumers may highlight which counties are most likely to be influenced by government system improvement efforts and which counties may under-utilize public mental health funding opportunities.

For each county in 2011, the table below displays the estimated number of adults and youth with any mental illness, the unduplicated number of mental health consumers served using Medicaid or the county public system, and the percentage served.

Utilization of the Publicly-Funded Mental Health Services by County in 2011

County	Estimated Number of Adults w/AMI (19.0%)	# of Adults Served with Public Funds	% of Adults w/AMI Served with Public Funds	Estimated Number of Youth w/AMI (21.0%)	# of Youth Served with Public Funds	% of Youth w/AMI Served with Public Funds
Adams	3,300	1,213	36.8%	532	486	91.4%
Ashland	2,362	1,326	56.1%	567	425	74.9%
Barron	6,810	2,439	35.8%	1,542	752	48.8%
Bayfield	2,328	614	26.4%	455	320	70.4%
Brown	35,980	10,491	29.2%	9,399	3,456	36.8%
Buffalo	2,015	374	18.6%	460	151	32.8%
Burnett	2,377	769	32.4%	469	308	65.7%
Calumet	6,905	1,220	17.7%	2,061	560	27.2%
Chippewa	9,157	2,619	28.6%	2,224	1,135	51.0%
Clark	4,687	1,593	34.0%	1,520	532	35.0%
Columbia	8,335	1,836	22.0%	2,048	710	34.7%
Crawford	2,478	1,002	40.4%	579	342	59.0%
Dane	74,123	13,771	18.6%	15,918	4,988	31.3%
Dodge	13,191	3,228	24.5%	3,021	1,273	42.1%
Door	4,338	1,110	25.6%	783	388	49.5%
Douglas	6,596	2,360	35.8%	1,430	730	51.1%
Dunn	6,674	1,923	28.8%	1,373	594	43.3%
Eau Claire	15,062	4,212	28.0%	3,121	1,545	49.5%
Florence	700	205	29.3%	122	58	47.5%
Fond du Lac	15,037	4,953	32.9%	3,554	1,679	47.2%
Forest	1,374	615	44.8%	319	289	90.5%
Grant	7,700	2,050	26.6%	1,633	689	42.2%
Green	5,337	1,467	27.5%	1,374	521	37.9%
Green Lake	2,807	801	28.5%	680	274	40.3%
Iowa	3,396	1,022	30.1%	877	341	38.9%
Iron	935	425	45.5%	158	169	*107.0%
Jackson	3,027	791	26.1%	706	326	46.2%
Jefferson	12,203	3,394	27.8%	3,071	1,180	38.4%
Juneau	4,009	1,524	38.0%	873	524	60.0%
Kenosha	23,730	6,955	29.3%	6,632	2,572	38.8%
Kewaunee	3,011	662	22.0%	757	267	35.3%
La Crosse	17,357	5,431	31.3%	3,665	1,821	49.7%
Lafayette	2,386	645	27.0%	659	278	42.2%
Langlade	2,987	1,385	46.4%	643	542	84.3%
Lincoln	4,262	1,616	37.9%	988	586	59.3%
Manitowoc	12,014	2,678	22.3%	2,801	1,085	38.7%

Utilization of Publicly-Funded Mental Health Services by County in 2011 (continued)

County	Estimated Number of Adults w/AMI (19.0%)	# of Adults Served with Public Funds	% of Adults w/ AMI Served with Public Funds	Estimated Number of Youth w/AMI (21.0%)	# of Youth Served with Public Funds	% of Youth w/ AMI Served with Public Funds
Marathon	19,360	5,989	30.9%	5,008	2,221	44.3%
Marinette	6,345	2,402	37.9%	1,324	1,033	78.0%
Marquette	2,350	756	32.2%	486	244	50.2%
Menominee	551	359	65.1%	206	187	91.0%
Milwaukee	135,895	47,013	34.6%	34,969	17,673	50.5%
Monroe	6,352	1,866	29.4%	1,764	828	46.9%
Oconto	5,556	1,521	27.4%	1,297	599	46.2%
Oneida	5,578	2,419	43.4%	1,008	869	86.2%
Outagamie	25,463	6,724	26.4%	6,800	2,466	36.3%
Ozaukee	12,677	1,584	12.5%	3,241	464	14.3%
Pepin	1,086	221	20.4%	259	92	35.5%
Pierce	6,073	1,068	17.6%	1,380	365	26.5%
Polk	6,424	2,129	33.1%	1,600	809	50.6%
Portage	10,600	2,618	24.7%	2,192	885	40.4%
Price	2,163	815	37.7%	426	221	51.8%
Racine	28,017	6,860	24.5%	7,414	2,935	39.6%
Richland	2,629	1,251	47.6%	632	372	58.8%
Rock	22,955	7,077	30.8%	6,110	2,920	47.8%
Rusk	2,166	850	39.2%	506	300	59.3%
St. Croix	11,805	2,842	24.1%	3,537	1,132	32.0%
Sauk	9,038	2,812	31.1%	2,270	1,011	44.5%
Sawyer	2,504	920	36.7%	517	306	59.2%
Shawano	6,176	2,189	35.4%	1,463	888	60.7%
Sheboygan	16,727	4,084	24.4%	4,230	1,253	29.6%
Taylor	2,974	884	29.7%	768	328	42.7%
Trempealeau	4,189	1,145	27.3%	1,057	350	33.1%
Vernon	4,206	1,074	25.5%	1,199	327	27.3%
Vilas	3,367	1,158	34.4%	581	439	75.6%
Walworth	15,075	4,450	29.5%	3,690	1,464	39.7%
Washburn	2,424	869	35.8%	488	299	61.3%
Washington	19,113	4,669	24.4%	5,034	1,723	34.2%
Waukesha	56,794	7,966	14.0%	14,940	2,906	19.5%
Waupaca	7,793	2,395	30.7%	1,836	813	44.3%
Waushara	3,758	1,066	28.4%	761	565	74.2%
Winnebago	25,054	7,383	29.5%	5,459	2,452	44.9%
Wood	11,026	4,098	37.2%	2,573	1,638	63.7%
Wisconsin Total	**833,256**	**232,245**	**27.9%**	**204,041**	**85,273**	**41.8%**

* The artificially high rate for youth in Iron County is possibly due to the national AMI rate of 21% not being appropriate for Iron County and/or the number of children served being over-reported.

Overall, a higher percentage of youth consumers (42%) receive publicly-funded treatment than adults (28%). Given that a higher percentage of youth than adults are in poverty and public systems serve a large majority of low-income individuals, this result may be expected. The other difference between adult and youth public treatment rates is the variability among counties. The range of public treatment rates for adults ranges from 12-65% while the youth treatment rates range from 14-100%. Thus, while the public treatment rates may be higher for youth on average, there are a subset of counties with relatively low treatment rates that could be examined further to determine why they are under-utilizing publicly-funded treatment.

Counties with the highest youth public treatment rates over 80% were Adams, Forest, Iron, Langlade, Menominee, and Oneida. Waukesha and Ozaukee had the lowest youth public treatment rates. Counties with the highest adult public treatment rates over 50% included Ashland and Menominee. Counties adult public treatment rates under 20% included Buffalo, Calumet, Dane, Ozaukee, Pierce, and Waukesha.

Since public county and Medicaid recipients only are examined here, low treatment rates does not necessarily mean that a county has low treatment rates overall. Counties with higher average incomes are likely to have more individuals using private insurance and fewer using publicly-funded treatment. Waukesha and Ozaukee, who have low public treatment rates, also have the two highest per capita incomes in the state[58] and likely have a larger proportion of adults who use private insurance as a result. The opposite may be true for counties with lower than average per capita incomes. Future analyses will attempt to include county-specific data from the commercial insurers to obtain overall treatment rates.

Demographic and Other Disparities in Access to Mental Health Treatment

Do various population groups have service access issues? Data on the proportion of services received by population groups can shed light on whether or not they are underserved. Young adults aged 18 to 25 with mental health symptoms were less likely than their older counterparts to have received mental health services (29.4% vs. 47.2% among those aged 26 to 49 and 53.8% among those aged 50 or older) [52]. In addition, females were more likely to have received services than males (49.2 vs. 36.7%), and whites were more likely than Hispanics and blacks to have received mental health services (50.9 vs. 29.6 and 26.0%, respectively).

According to Wisconsin's prevalence estimates, the highest rate of any mental illness (AMI) among racial groups was 21.6% of Native Americans in 2010. Out of 54,526 adults in the state based on the 2010 U.S. Census, this means that 11,778 Native Americans have a mental health need compared to the 1,462 Native Americans who were served through the public mental health system in CY 2010 according to the State's Human Services Reporting System (HSRS). Based on the estimated prevalence of 11,778 Native Americans with a mental health need in Wisconsin within a year, the public county mental health system served 12.4 percent.

The Department of Justice’s Survey of Inmates in State and Federal Correctional Facilities (2004) and Survey of Inmates in Local Jails (2002) also indicate that fewer than half of inmates who have a mental health problem have ever received treatment for their problem[59]. A third or fewer received mental health treatment after admission. These rates differ depending upon the type of correctional facility.

Disparities in Substance Abuse Treatment

Do various population groups have service access issues? Data on the proportion of services received by population groups can shed light on whether or not they are underserved. Previously we stated that White males, living in urban areas and having an alcohol use disorder make up a large percentage of persons receiving substance abuse services. The table that follows describes the relative distribution of services to selected population groups compared to their substance abuse prevalence. National Survey on Drug Use and Health[9] (NSDUH) and Human Services Reporting System (HSRS) data are analyzed. Females, youth, persons age 65 and over, and Hispanic persons are underserved in proportion to their substance abuse prevalence.

	Percent of Substance Abuse Prevalence, 2009-2010 Combined, NSDUH		**Percent of Substance Abuse Clients Served, 2010, HSRS**	
	#	**%**	**#**	**%**
Female	149,674	33.4%	15,635	28%
Age under 18	39,986	8.9%	1,117	2%
Age 65 and over	13,214	2.9%	1,005	1.8%
White	387,896	86.6%	45,789	82%
Black	25,282	5.6%	5,584	10%
Hispanic	25,079	5.6%	2,234	4%
Native American	6,075	1.4%	1,675	3%
Asian	3,668	0.8%	558	1%
Total	448,000		55,840	

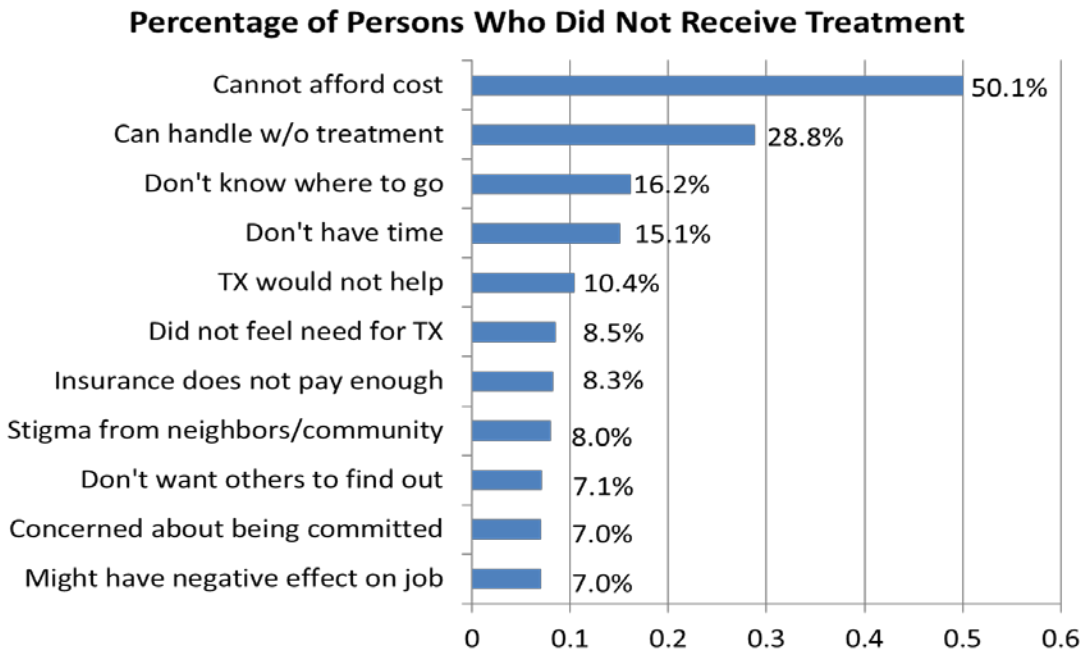
Opiates

Previously we determined that the minimum annual prevalence of Wisconsin adults needing treatment for heroin or other opiate addiction is estimated to be 30,450 persons. Human Services Reporting System (HSRS; County-authorized services) data indicate that 5,848 persons received treatment for opiate abuse or dependence in 2010. While the HSRS data does not include services authorized under Medicaid or private insurance, there is an indication that opiate abusers are underserved.

Barriers to Accessing Mental Health Treatment – the Consumers' Perspective

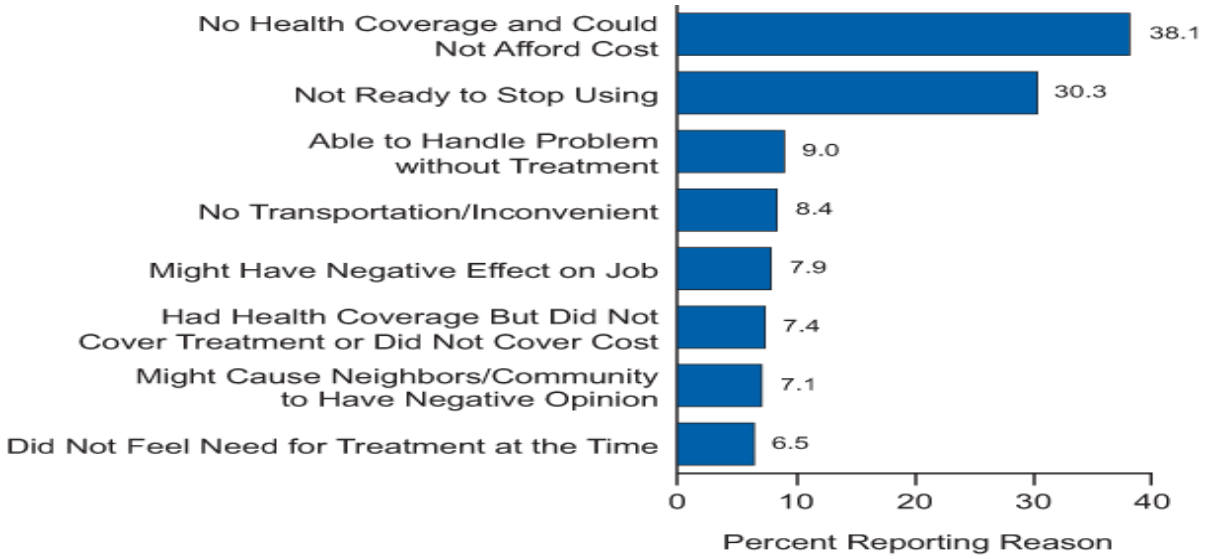
What are the barriers to receiving mental health treatment? The NSDUH survey asks a nationally representative sample of people annually about whether they had a mental health need, if they received treatment, and if they experienced barriers to accessing treatment. In 2011, respondents who had an unmet mental health need for treatment cited the top ten reasons in the chart below for why they did not access treatment[60] (multiple answers could be given). Far and above any other reason for not receiving treatment, cost was cited as the number one reason by half of respondents. Just under 30% of people indicated they could handle their problems without treatment and another 8.5% felt they didn't need treatment at all. The third and fourth ranked reasons were that people didn't know where to go or didn't have time for treatment. About 7-8% of persons indicated at least one of three reasons related to stigma including the risk of feeling stigma in the community, among others/friends, or at work.

Reasons for Not Receiving Mental Health Treatment (NSDUH 2011)



The Consumer's Perspective – Substance Abuse Treatment

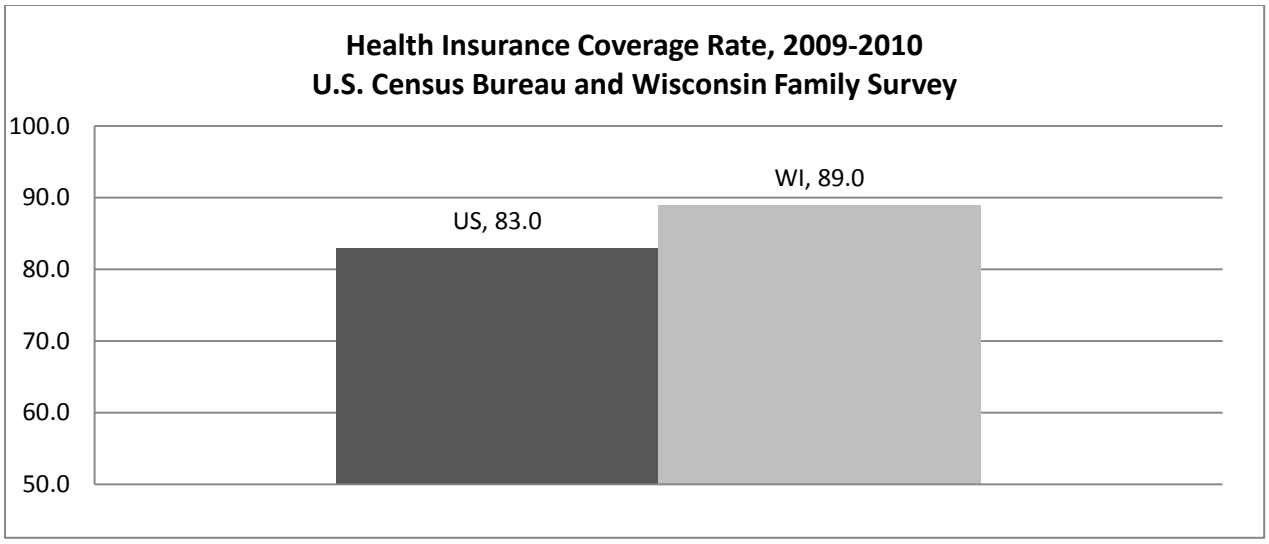
Another important perspective on the service access issue is from the potential consumer or client viewpoint. What are the reasons persons don't receive substance abuse treatment? There are recent U.S. data available from the National Survey on Drug Use and Health that describe the most frequent reasons given[9] (see the graph below).



Persons' perceptions that they do not have a serious enough problem or just don't want help top the list of reasons for not receiving substance abuse treatment at 45.8% (combines 30.3% + 9.0% + 6.5%). No or inadequate health insurance is the close second most frequent reason cited at 45.5% and stigma (15%) is third.

According to the U.S. Census Bureau, Wisconsin, at 89%, is among the top three states in the Country for the percent of the population having health insurance.[61, 62] The national average is 83% (see the chart below). While this is generally a good thing for people having physical health issues or medical conditions, according to the National Survey on Drug Use and Health only about 61% of persons with substance use disorders have public or private health insurance. Only about 76% of persons with any mental illness (AMI) have public or private health insurance and just 57% of persons with serious mental illness (SMI) have health insurance. This low rate of health insurance creates a barrier to receiving treatment. Protecting or increasing public funding and affordable insurance has been identified by stakeholders as priority needs.

The Wisconsin Division of Public Health conducts its own annual Family Health Survey data from a representative sample of Wisconsin residents. Combined 2008-2010 results confirm that 89% have insurance the entire year[63]. Another 5% have insurance for part of the year and 6% are uninsured all year. The counties with the highest rate of uninsured persons were Clark (21%), Vilas (16%), Oconto (12%), and Vernon (12%).



Stigma has been identified by stakeholders as a priority. Stigma is when someone negatively judges you based on a personal trait or condition. Unfortunately this is a common experience for people who have a mental health or substance use condition. Stigma may be obvious and direct, such as someone making a negative remark about your mental illness or your treatment. Or it may be subtle, such as an individual or organization assuming you could be unstable, violent or dangerous because you have a certain condition. Some of the harmful effects of stigma include:

- Discrimination in employment, education or housing
- Bullying, physical violence or harassment
- Health insurance that doesn't adequately cover your mental illness care needs
- The belief that you will never be able to succeed at certain things or that you can't improve your situation
- Withdrawing from society and isolation

According to the National Survey on Drug Use and Health, 15% of potential substance abuse treatment consumers and 22% of potential mental health service consumers identify stigma as the reason they do not seek or receive treatment.

Mental Health Promotion/Prevention Considerations

Mental health promotion and prevention consists of implementing evidence-based and best-practice interventions to address high priority needs, such as those identified in this needs assessment. The key to mental illness prevention lies in early intervention, with a particular focus on childhood development. This is supported by the dramatic findings from the Adverse Childhood Experiences (ACE) study[115] led by Drs. Anda and Felitti in collaboration with Kaiser Permanente and the Centers for Disease Control and Prevention. Adverse childhood experiences includes but is not limited to being abused, having divorced parents, or living in a household with anyone who had a mental illness or substance use disorder. The ACE study identified correlations between ACEs and poor outcomes across a wide range of measures of adult health and well-being. Adults who reported more ACEs also reported increased mental health problems, substance use, and suicide attempts, as well as certain chronic diseases.

Wisconsin-specific ACE data has been collected and analyzed, resulting in a document entitled, Adverse Childhood Experiences in Wisconsin: Findings from the 2010 Behavioral Risk Factor Survey[116]. Many of the original ACE correlations were confirmed within the Wisconsin cohort, including the finding that Wisconsinites with higher ACE scores were more likely than people with no ACEs to have been diagnosed with anxiety or depression at some point in their life. Additionally, 56% of Wisconsin adults were found to have experienced at least one ACE and 14% were found to have experienced four or more. With the awareness of the devastating impact of ACEs, there is a focus on finding resources that will prevent, reduce, or change the life course predicted by high ACE scores. As such, resilience research is on the rise, providing direction for individuals, families, communities, organizations, and systems of care. With this knowledge, Wisconsin is looking to a population-based approach to prevent exposure to and increase protection from the negative long-term impact of ACEs.

One way to prevent the negative long-term impact of ACEs on the mental health of Wisconsin citizens is early identification of those who have experienced ACEs coupled with proven interventions to build resilience. To that end, a broad-based Wisconsin coalition has plans to develop an ACE & Resilience Screener and Resilience Tool Kit, as well as convene a Learning Institute where stakeholders and national technical assistance advisors currently working in Wisconsin will gain concrete tools to integrate ACE and Resilience knowledge into practice within child-serving systems.

For mental health promotion, one vital initiative is in the area of Infant Mental Health, where the focus is on promoting the healthy social and emotional development of the youngest Wisconsin children. One goal is to provide parents and people working with young children and their families (e.g., child care workers, home visitors, and pediatricians) the knowledge, skills, and practices that support healthy social and emotional development. These mental health promotion activities are supported by research, such as that done by the Center for the Developing Child at Harvard University, showing that early influences – both positive and negative – have a critical impact on the development of children's brains and their lifelong health, including mental health.

Substance Abuse Prevention Considerations

The Federal Substance Abuse and Mental Health Services Administration endorses the Institute of Medicine's (IOM) prevention strategy types. While all of the IOM's prevention strategies are helpful in abating community substance abuse problems, the Wisconsin Division of Mental Health and Substance Abuse Services has determined that the universal indirect prevention strategies produce the most widespread and lasting positive impact on community substance abuse problems. Universal indirect prevention strategies address the entire population with approaches aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. In universal indirect prevention the entire population is considered: 1) part of the solution; 2) at-risk for substance abuse; and 3) capable of benefiting from prevention strategies. Included are "environmental" strategies which establish or change written and unwritten school and community alcohol/drug use standards, codes, laws, mores, attitudes and culture. On-going community-at-large events such as fairs, school assemblies, or the widespread dissemination of information and messages are also considered universal indirect prevention strategies.[64,65]

Access to universal indirect prevention strategies has been identified as a priority by stakeholders, the State Council on Alcohol and Other Drug Abuse, the Wisconsin State Health Plan, and the Division of Mental Health and Substance Abuse Services. What is the availability of universal indirect prevention strategies across Wisconsin's Counties? An analysis of 2011 Substance Abuse Prevention Services Information System (SAPSIS) data show that 9 of Wisconsin's 11 tribal nations and 30 of Wisconsin's 72 (42%) Counties did not report universal indirect prevention strategy activities indicating a probable lack of access to these effective services.[66]

III. SERVICE AND WORKFORCE CAPACITY

The purpose of the data analysis in this report section is to examine data on the availability and capacity of prevention strategies and treatment services. Areas that will be analyzed include service utilization and workforce capacity to demonstrate to what degree the MH/SA service systems can meet the needs of consumers. Ideally, the number of workforce FTE's compared to the number of persons with MH/SA needs would be used to demonstrate whether the service systems had adequate capacity, but statewide workforce FTE data is not always available. When absent, service utilization data will be used instead to demonstrate the volume and array of services available to treat persons with MH/SA needs. Comparisons with national data and analysis of disparities among selected population groups will be made where data is available.

Substance Abuse Prevention

An analysis of state or federal prevention grant funds (such as Brighter Futures, Special Incentive Grant, Alliance for Wisconsin Youth, Drug-Free Communities, etc.) going to Counties revealed that 22 of Wisconsin's 72 Counties (Barron, Bayfield, Buffalo, Burnett, Clark, Door, Florence, Green, Green Lake, Juneau, Kewaunee, Lafayette, Langlade, Marinette, Oconto, Pepin, Price, Richland, Rusk, Sauk, Shawano and Taylor) did not receive any special prevention grant funds beyond the 20% set-aside funds provided under the Federal substance abuse block grant.[67] The 20% prevention set-aside funds going to Counties average $8,000 per County. These 22 Counties represent over 600,000 Wisconsin residents. Furthermore, a list of active, grassroots youth prevention coalitions within Counties maintained by the Alliance for Wisconsin Youth further indicates that 3 of these 22 Counties (Juneau, Lafayette and Sauk) do not have a grassroots youth prevention coalition.

Substance Abuse Treatment

An effective and appropriate array and utilization of treatment services will ensure appropriate access and achieve efficiencies in the use of limited public funds and resources, but are some treatment services over- or under-utilized?

In 2010, Wisconsin Human Services Reporting System data showed that 55,840 persons came in contact with the publically supported substance abuse services system:

General Service Category	# of Persons	% of Persons
Detox	7,023	12.6%
Various Inpatient, Residential and Outpatient Levels of Care	24,899	44.6%
Brief Evaluation, Case Management or Ancillary Services	23,918	42.8%

In general, for substance abuse services, females receive outpatient at a slightly higher rate than males and males receive detox at a higher rate than females. Older adults (age 55 and older) receive outpatient at a lower rate than middle aged and young adults but older adults receive detox at a higher rate. Youth age 17 and under use detox much less than adults but youth use day treatment more than adults. No differences in specific substance abuse service levels of care were found for racial/ethnic groups. Wisconsin Counties (excluding Milwaukee) with urban areas utilize less inpatient, day treatment, case management, and medically managed detox than rural counties, but urban counties utilize more residential and medically monitored detox.

The approach used in the analysis and tables that follow integrates treatment utilization data and estimation approaches to produce an approximation of the gaps in treatment services. The analysis is derived from consumer-level service data from states identified as having relatively lower utilization of high-end detox and inpatient services. In addition, Wisconsin's Human Services Reporting System (HSRS or County-authorized services) and Wisconsin's Medicaid Management Information System data are analyzed.[68] There are some limitations to this analysis that should be noted:

- Large data systems can have sources of sampling, coding and reporting variability and error
- Much of the information in this analysis relies on national, selected states or Wisconsin statewide data that when applied to Wisconsin or its counties should be interpreted with caution

If 100 people sought services for substance abuse, what base array of services would be expected to be available? The table following presents composite state and national substance abuse service distribution data available from Wisconsin's Medicaid Management Information System (MA), Wisconsin's HSRS, and the Federal Treatment Episode Data Set (TEDS). All states report into TEDS and Wisconsin uses its HSRS data to populate the Federal TEDS database. The column at the far right is a composite average of the level of care data and is the recommended benchmark. As an example, out of 100 people seeking substance abuse treatment, 1 will need inpatient, 2 will need hospital detox, 7 will need residential detox, 1 will need ambulatory detox, 7 will need primary residential treatment, 7 will need transitional residential treatment, 12 will need day treatment or intensive outpatient, 62 will need regular outpatient, etc.

Service/Benefit	Wisconsin MA, 2008	Wisconsin HSRS, 2008	Five States Examined in the County Infrastructure Study TEDS, 2008	States with Low Inpatient and Detox Usage TEDS, 2008*	Composite Average (omits MA data)
Inpatient	6.7%	.3%	1.6%	.4%	.8%
Detox - medically managed		4.7%	.2%	.9%	1.9%
Detox – medically monitored or residential	N.A.	10.2%	6.5%	4.8%	7.2%
Ambulatory detox	Included in outpatient	<.1%	.5%	1.6%	.7%
Residential primary, short term	N.A.	5.9%	6.7%	9.5%	7.3%
Residential transitional, long term	N.A.	4.1%	7.4%	8.4%	6.6%
Day treatment**	1.4%	3.2%	14.7%	19.0%	12.3%
Community Support Program	<.1%	<.1%	N.A.	N.A.	<.1%
Comprehensive Community Services	<.1%	<.1%	N.A.	N.A.	<.1%
Outpatient (includes case management)	91.9%	69.2%	62.4%	55.4%	62.1%
Vocational	N.A.	.3%	N.A.	N.A.	.2%
Supportive housing	N.A.	.4%	N.A.	N.A.	.2%
Child care	N.A.	.1%	N.A.	N.A.	.2%
Transportation	N.A.	.3%	N.A.	N.A.	.2%
Crisis intervention	N.A.	.4%	N.A.	N.A.	.2%

*Alabama, Arizona, California, Florida, Hawaii, Idaho, Indiana, Iowa, Louisiana, Maine, Maryland, Minnesota, Mississippi, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Virginia, Washington, West Virginia, Wyoming

**There was difficulty distinguishing between day treatment and intensive outpatient in the various data sets.

The table on the next two pages presents actual County level of service data reported in the Human Services Reporting System. This analysis enables policy makers and other stakeholders a means of comparing each County's actual service array to the recommended benchmark service array. In general, Wisconsin's publicly supported substance abuse services system over-utilizes detox services and under-utilizes primary residential and day treatment/intensive outpatient levels of care.

WISCONSIN COUNTY MENTAL HEALTH AND SUBSTANCE ABUSE INFRASTRUCTURE INITIATIVE

Substance Abuse: 2008 Service/Benefit Base Estimates and Admissions Distribution - Gap

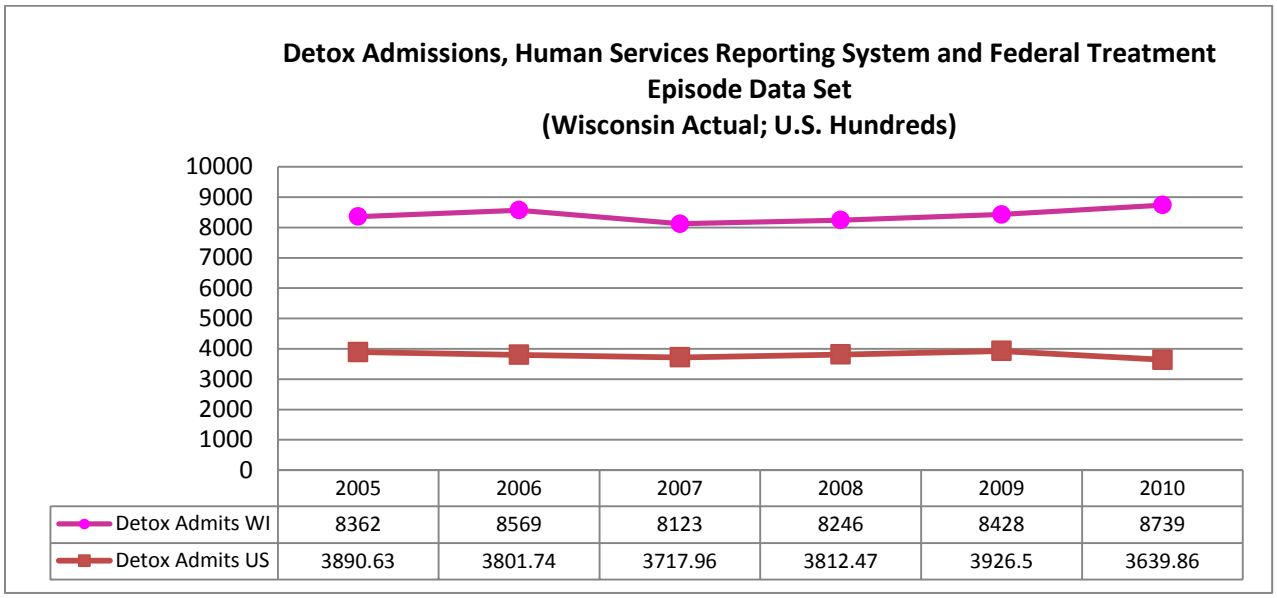
	Inpatient	Medically Managed Detox	Other Residential Detox	Ambulatory Detox	Short-term Residential	Long-term Residential	Day Treatment	Community Support Program	Comprehensive Community Services*	Outpatient	Vocational	Supportive Housing	Child Care*	Transportation	Crisis Intervention
Service Base Estimates	0.8%	1.9%	7.2%	0.7%	7.3%	6.6%	12.3%	<.1%	<.1%	62.1%	0.2%	0.2%	0.2%	0.2%	0.2%
Adams	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	CCS	97.9%	0.0%	0.0%		0.0%	0.0%
Ashland	14.0%	5.4%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%		76.0%	0.0%	1.6%		1.6%	0.0%
Barron	0.3%	6.5%	0.0%	0.0%	13.0%	7.2%	0.0%	0.0%		62.1%	0.0%	1.4%		3.1%	6.5%
Bayfield	0.8%	19.7%	0.0%	0.0%	6.3%	0.8%	1.6%	0.0%		69.3%	0.0%	0.8%		0.0%	0.8%
Brown	0.0%	41.8%	0.2%	0.0%	12.7%	4.0%	0.0%	0.0%	CCS	32.2%	1.0%	3.4%		4.1%	0.0%
Buffalo	8.0%	12.0%	0.0%	0.0%	20.0%	20.0%	4.0%	0.0%		32.0%	4.0%	0.0%		0.0%	0.0%
Burnett	0.0%	3.8%	0.0%	0.0%	5.7%	4.7%	0.0%	0.0%		84.0%	0.0%	0.9%		0.0%	0.9%
Calumet	0.5%	12.0%	1.1%	0.0%	1.6%	4.9%	0.0%	0.0%	CCS	65.8%	3.8%	0.0%		10.3%	0.0%
Chippewa	1.6%	20.7%	0.0%	0.0%	0.0%	8.8%	0.0%	0.0%		69.0%	0.0%	0.0%		0.0%	0.0%
Clark	0.8%	0.0%	0.0%	0.0%	0.8%	2.4%	0.0%	0.0%		95.9%	0.0%	0.0%		0.0%	0.0%
Columbia	0.6%	0.0%	27.2%	0.0%	0.0%	4.8%	0.0%	0.0%		65.7%	0.0%	0.0%		0.0%	1.6%
Crawford	0.0%	4.5%	0.0%	0.0%	0.0%	12.6%	0.0%	0.0%		81.1%	0.0%	1.8%		0.0%	0.0%
Dane	0.0%	0.0%	48.6%	0.0%	0.0%	9.8%	2.8%	0.0%		38.8%	0.0%	0.0%	CC	0.0%	0.0%
Dodge	0.0%	0.6%	16.4%	0.0%	0.0%	2.4%	0.0%	0.2%	CCS	80.1%	0.0%	0.0%		0.0%	0.4%
Door	0.0%	16.9%	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%		77.5%	0.0%	0.0%		0.0%	0.0%
Douglas	0.0%	54.9%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%		19.8%	0.3%	0.0%		0.0%	0.0%
Dunn	0.0%	5.5%	0.0%	0.0%	23.6%	10.9%	6.4%	0.0%		53.6%	0.0%	0.0%		0.0%	0.0%
Eau Claire	0.0%	19.3%	0.0%	0.0%	3.3%	5.2%	0.0%	2.3%		67.4%	0.2%	0.4%	CC	1.9%	0.0%
Florence	0.0%	0.0%	3.7%	0.0%	14.8%	0.0%	0.0%	0.0%		81.5%	0.0%	0.0%		0.0%	0.0%
Fond du Lac	0.1%	19.9%	0.0%	0.0%	0.1%	1.9%	0.0%	0.0%	CCS	75.4%	0.0%	0.0%		0.0%	2.5%
Forest-Oneida-Vilas	0.7%	7.9%	2.1%	0.0%	14.0%	0.0%	0.0%	0.0%	CCS	75.2%	0.0%	0.1%		0.0%	0.1%
Grant-Iowa	0.0%	6.4%	9.1%	0.0%	0.0%	1.1%	0.0%	0.0%		83.5%	0.0%	0.0%		0.0%	0.0%
Green	0.0%	0.0%	8.8%	0.0%	0.0%	0.0%	0.0%	0.0%	CCS	90.7%	0.0%	0.0%		0.0%	0.5%
Green Lake	0.0%	0.0%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	CCS	97.8%	0.0%	0.0%		0.0%	0.0%
Iron	3.6%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		91.1%	0.0%	0.0%		0.0%	0.0%
Jackson	3.0%	10.5%	0.0%	0.0%	3.0%	2.3%	0.0%	0.0%		81.2%	0.0%	0.0%		0.0%	0.0%
Jefferson	0.0%	0.0%	12.5%	0.0%	0.0%	2.6%	0.0%	0.0%	CCS	84.9%	0.0%	0.0%		0.0%	0.0%
Juneau	0.0%	1.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%		96.6%	0.0%	0.0%		0.0%	0.0%
Kenosha	0.0%	4.9%	35.7%	0.0%	0.0%	0.0%	0.0%	0.4%	CCS	59.0%	0.0%	0.0%	CC	0.0%	0.0%
Kewaunee	0.0%	14.7%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%	CCS	69.0%	0.0%	0.0%		0.0%	12.5%
La Crosse	0.0%	10.3%	0.2%	0.0%	4.1%	8.7%	0.5%	0.7%	CCS	75.5%	0.0%	0.0%	CC	0.0%	0.0%
Lafayette	0.5%	0.0%	0.5%	0.0%	0.5%	2.0%	0.0%	0.0%		96.0%	0.5%	0.0%		0.0%	0.0%

	Inpatient	Medically Managed Detox	Other Residential Detox	Ambulatory Detox	Short-term Residential	Long-term Residential	Day Treatment	Community Support Program	Comprehensive Community Services*	Outpatient	Vocational	Supportive Housing	Child Care*	Transportation	Crisis Intervention
Service Base Estimates	0.8%	1.9%	7.2%	0.7%	7.4%	6.6%	12.3%	<.1%	<.1%	62.1%	0.2%	0.2%	0.2%	0.2%	0.2%
Langlade-Lincoln-Marathon	3.9%	12.9%	0.0%	0.0%	0.0%	1.6%	8.9%	0.2%	CCS	72.4%	0.0%	0.0%	CC	0.0%	0.0%
Manitowoc	0.0%	16.2%	0.0%	0.0%	2.8%	22.5%	0.0%	0.0%	CCS	58.5%	0.0%	0.0%		0.0%	0.0%
Marinette	0.6%	0.3%	0.0%	0.0%	1.9%	0.9%	0.0%	0.0%		96.2%	0.0%	0.0%		0.0%	0.0%
Marquette	0.0%	0.6%	6.8%	0.0%	0.0%	0.0%	0.0%	0.0%		92.5%	0.0%	0.0%		0.0%	0.0%
Menominee	0.0%	4.3%	0.0%	0.0%	7.1%	0.0%	0.0%	0.0%	CCS	82.9%	0.0%	0.0%		0.0%	5.7%
Milwaukee	0.0%	0.0%	25.6%	0.0%	0.5%	6.8%	5.9%	0.0%		59.8%	1.5%	0.0%	CC	0.0%	0.0%
Monroe	0.8%	1.6%	0.0%	0.0%	1.4%	4.3%	0.0%	0.0%		91.8%	0.0%	0.0%		0.0%	0.0%
Oconto	0.0%	22.3%	3.9%	0.0%	8.7%	1.0%	0.0%	0.0%		64.1%	0.0%	0.0%		0.0%	0.0%
Outagamie	0.0%	7.9%	0.0%	0.0%	1.5%	12.3%	15.1%	0.0%	CCS	59.7%	0.0%	3.5%		0.0%	0.0%
Ozaukee	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		100.0%	0.0%	0.0%		0.0%	0.0%
Pepin	0.0%	6.7%	0.0%	0.0%	20.0%	13.3%	6.7%	0.0%		53.3%	0.0%	0.0%		0.0%	0.0%
Pierce	1.1%	6.5%	0.5%	0.0%	0.5%	1.1%	0.0%	0.0%		90.2%	0.0%	0.0%		0.0%	0.0%
Polk	0.0%	1.4%	0.0%	0.0%	1.8%	2.5%	0.0%	0.0%		94.3%	0.0%	0.0%		0.0%	0.0%
Portage	0.0%	5.5%	0.0%	0.0%	0.0%	3.2%	2.2%	0.0%	CCS	89.1%	0.0%	0.0%		0.0%	0.0%
Price	15.2%	21.2%	0.0%	0.0%	6.1%	0.0%	0.0%	0.0%		57.6%	0.0%	0.0%		0.0%	0.0%
Racine	0.0%	6.4%	36.9%	0.0%	0.0%	17.8%	0.0%	0.0%		38.9%	0.0%	0.0%		0.0%	0.0%
Richland	0.0%	0.8%	3.2%	0.0%	1.6%	3.2%	0.0%	0.0%	CCS	91.3%	0.0%	0.0%		0.0%	0.0%
Rock	0.0%	0.0%	36.3%	0.0%	6.0%	2.9%	0.0%	0.0%		54.8%	0.0%	0.0%		0.0%	0.0%
Rusk	7.1%	18.6%	0.0%	0.0%	1.4%	1.4%	0.0%	0.0%		71.4%	0.0%	0.0%		0.0%	0.0%
St. Croix	1.6%	9.9%	0.0%	0.2%	5.6%	1.1%	0.0%	0.0%	CCS	81.3%	0.0%	0.0%		0.0%	0.2%
Sauk	0.0%	3.0%	17.1%	0.0%	4.2%	0.5%	3.2%	0.0%	CCS	55.2%	0.0%	0.0%		0.0%	16.3%
Sawyer	2.1%	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		94.3%	0.0%	0.0%		0.0%	0.0%
Shawano	0.9%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	CCS	83.4%	0.0%	0.0%		0.0%	14.5%
Sheboygan	0.1%	9.8%	0.0%	0.0%	0.0%	4.5%	0.0%	0.1%	CCS	83.6%	0.4%	0.0%		0.0%	1.6%
Taylor	1.7%	3.4%	0.0%	0.0%	5.1%	0.8%	0.0%	0.0%		88.1%	0.0%	0.0%		0.0%	0.8%
Trempealeau	0.0%	9.8%	0.0%	0.0%	7.6%	8.7%	0.0%	0.0%		46.7%	0.0%	0.0%		0.0%	27.2%
Vernon	1.4%	1.4%	0.0%	0.0%	1.4%	6.8%	0.0%	0.0%		89.0%	0.0%	0.0%		0.0%	0.0%
Walworth	0.0%	25.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	CCS	74.7%	0.0%	0.0%		0.0%	0.0%
Washburn	0.0%	4.8%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%		93.3%	0.0%	0.0%		0.0%	0.0%
Washington	0.8%	12.3%	3.8%	0.0%	0.8%	8.5%	15.4%	0.0%	CCS	58.4%	0.0%	0.0%		0.0%	0.0%
Waukesha	0.0%	2.6%	8.1%	0.0%	4.7%	4.4%	0.8%	0.0%	CCS	74.3%	0.0%	1.6%	CC	3.6%	0.0%
Waupaca	0.0%	10.6%	0.0%	0.0%	1.0%	3.8%	0.0%	0.0%		74.0%	0.0%	1.0%		0.0%	9.6%
Waushara	0.0%	1.2%	0.0%	0.0%	3.7%	2.1%	0.0%	0.0%	CCS	92.9%	0.0%	0.0%		0.0%	0.0%
Winnebago	0.0%	2.7%	0.0%	0.0%	3.6%	3.9%	0.0%	0.0%	CCS	89.8%	0.0%	0.0%	CC	0.0%	0.0%
Wood	0.0%	7.2%	0.0%	0.0%	1.3%	6.6%	17.2%	0.0%	CCS	70.7%	0.0%	0.0%		0.0%	0.0%

Source: Human Services Reporting System, 2008; duplicated count; outpatient includes case management; assessments only not included in the data.

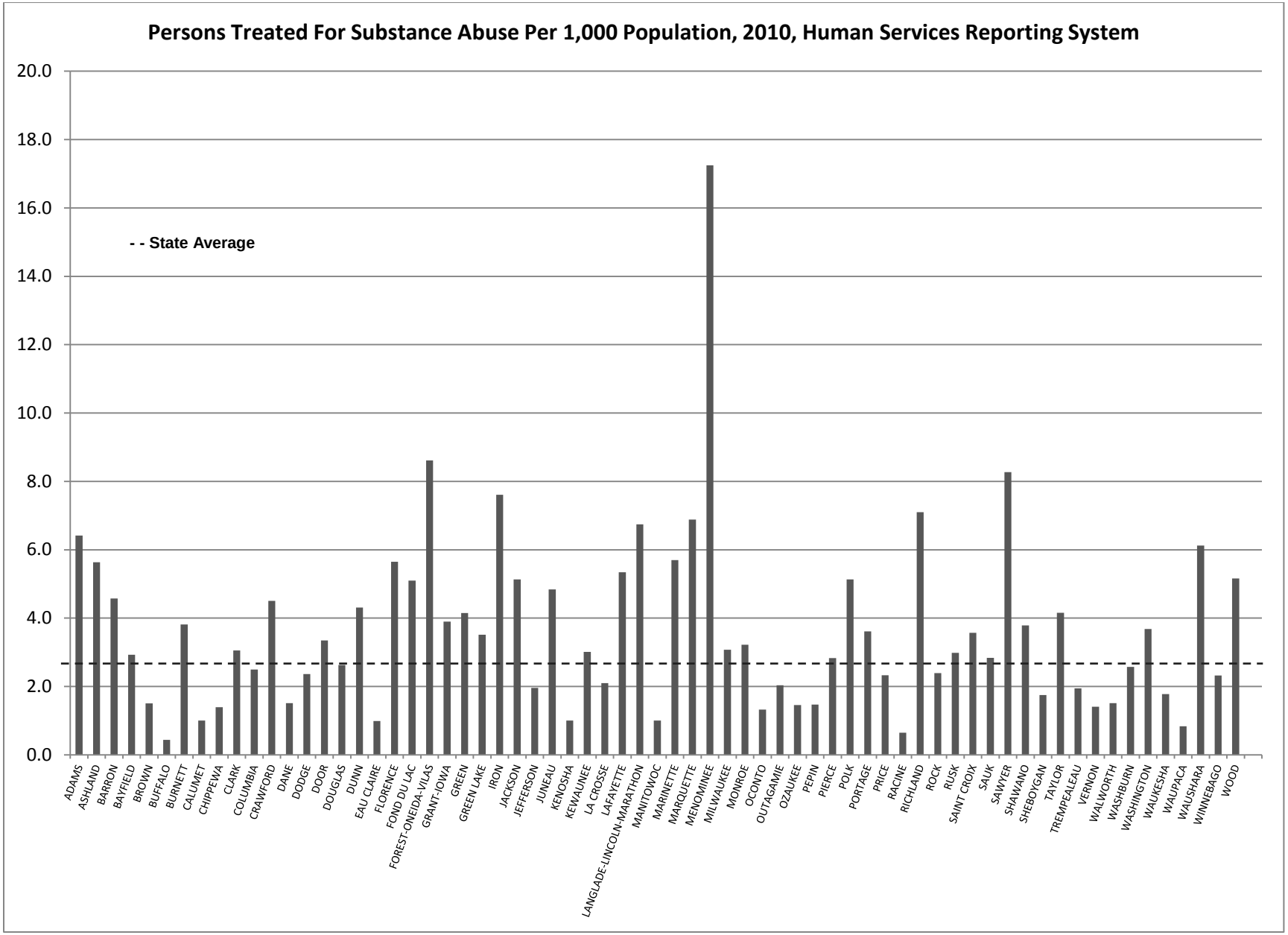
*No data available, however, Counties with significant activities are indicated.

The chart below looks more closely at Wisconsin's utilization of detox services subsidized with county and state funds. In order to compare the Wisconsin (WI) and U.S. trends on the same graph, the Wisconsin data are actual admissions and the U.S. data are expressed in hundreds (3890.63 hundreds = 389,063 actual U.S. admissions). The Wisconsin trend in detox admissions is upward while the U.S. trend is downward. Considering the previous table entitled, Wisconsin County Mental Health and Substance Abuse Infrastructure Initiative, there are several Counties that appear to have disproportionately high utilization of detox services (Bayfield, Brown, Chippewa, Columbia, Dane, Dodge, Door, Douglas, Eau Claire, Fond du Lac, Kenosha, Kewaunee, Manitowoc, Milwaukee, Oconto, Price, Rusk, Sauk and Walworth).



	2005	2006	2007	2008	2009	2010
Detox Admits WI	8362	8569	8123	8246	8428	8739
Detox Admits US	3890.63	3801.74	3717.96	3812.47	3926.5	3639.86

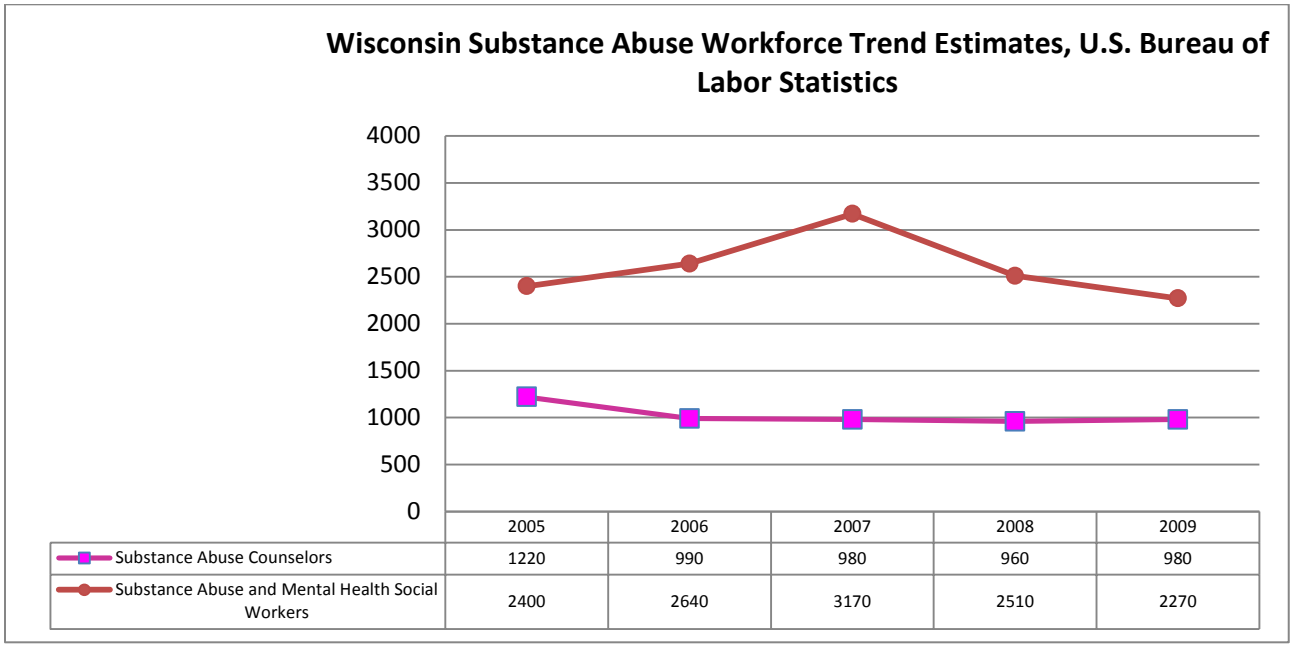
Do differences exist in the number of persons treated for a substance use disorder per capita by County? The chart on the following page displays the number of County-authorized persons treated per capita for each Wisconsin County agency in 2010. These data exclude detox and brief services such as evaluations. The differences can be explained by the County's substance abuse prevalence, amount of funding and revenue available for services, poverty rate, clinical staff turnover issues and data reporting practices. Further analysis is necessary to determine the explanation for an individual County's rate. Twenty-three (23 or 34%) County agencies are 50% higher than the state average; 8 (12%) County agencies are 50% lower than the state average; and 36 (54%) County agencies are within the state average.


Persons Treated For Substance Abuse Per 1,000 Population, 2010, Human Services Reporting System
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
- - State Average
ADAMS
ASHLAND
BARRON
BAYFIELD
BROWN
BUFFALO
BURNETT
CALUMET
CHIPPEWA
CLARK
COLUMBIA
CRAWFORD
DANE
DODGE
DOOR
DOUGLAS
DUNN
EAU CLAIRE
FLORENCE
FOND DU LAC
FOREST-ONEIDA-VILAS
GRANT-IOWA
GREEN
GREEN LAKE
IRON
JACKSON
JEFFERSON
JUNEAU
KENOSHA
KEWAUNEE
LA CROSSE
LAFAYETTE
LANGLADE-LINCOLN-MARATHON
MANITOWOC
MARINETTE
MARQUETTE
MENOMINEE
MILWAUKEE
MONROE
OCONTO
OUTAGAMIE
OZAUKEE
PEPIN
PIERCE
POLK
PORTAGE
PRICE
RACINE
RICHLAND
ROCK
RUSK
SAINT CROIX
SAUK
SAWYER
SHAWANO
SHEBOYGAN
TAYLOR
TREMPEALEAU
VERNON
WALWORTH
WASHBURN
WASHINGTON
WAUKESHA
WAUPACA
WAUSHARA
WINNEBAGO
WOOD

Substance Abuse Treatment Workforce

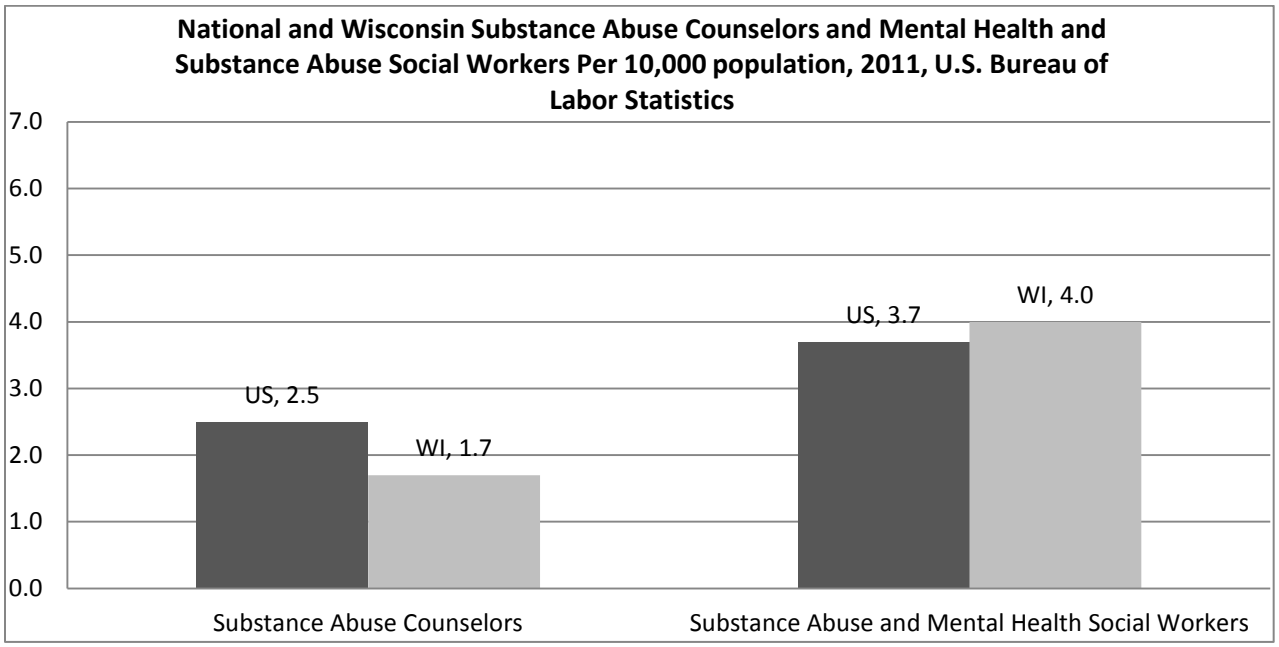
Does the demand for substance abuse counselors exceed the supply? Anecdotal complaints from several substance abuse treatment agencies and the 2012 Wisconsin substance abuse counselor survey have identified issues related to possible workforce shortages.[69] The agency complaints usually go like this, "We advertise widely in Wisconsin and we get no applicants." According to the Wisconsin Department of Safety and Professional Services there are an estimated 1,920 active or inactive, licensed or certified substance abuse treatment professionals in Wisconsin. Nine hundred sixty seven (967) responded to the 2012 Wisconsin substance abuse counselor survey. Previously in this report we discussed how Hispanic persons receive treatment at a rate lower than their occurrence among those in need of treatment. There is a related finding from the counselor survey indicating a need for more Hispanic counselors. Hispanic counselors comprised just 3% of the survey respondents while 5.6% of the prevalence of substance abusers are Hispanic persons. There is also a disproportionate rate (55%) of counselors age 51 and older with 24% of counselors at or near retirement age (age 60+) indicating that a crisis could be looming if the older counselors are not replaced by younger ones. In addition to the worker shortage issues, the survey found reports of inadequate compensation and stigma associated with the occupation of substance abuse counselor.

Also useful in this workforce analysis is data from the U.S. Bureau of Labor Statistics. In 2011, the U.S. Bureau estimates there are 980 employed substance abuse counselors in Wisconsin and another 2,270 professionals in the single category "mental health and substance abuse social workers".[70] These data are helpful in looking at trends and making comparisons with national averages. The following chart shows annual trends for Wisconsin workers indicating that the overall substance abuse professional workforce in Wisconsin may be shrinking while the U.S. Bureau is projecting a 33% increased need for substance abuse and mental health professionals by the year 2016.



	2005	2006	2007	2008	2009
Substance Abuse Counselors	1220	990	980	960	980
Substance Abuse and Mental Health Social Workers	2400	2640	3170	2510	2270

This next chart compares the Wisconsin substance abuse professional workforce per 10,000 population with the national average. The chart documents the need for 440 more Wisconsin substance abuse counselors and 165 fewer Wisconsin substance abuse and mental health social workers in order to match the national average. Overall there is a net need for 275 (440 minus 165) more Wisconsin substance abuse professionals to match the national average.



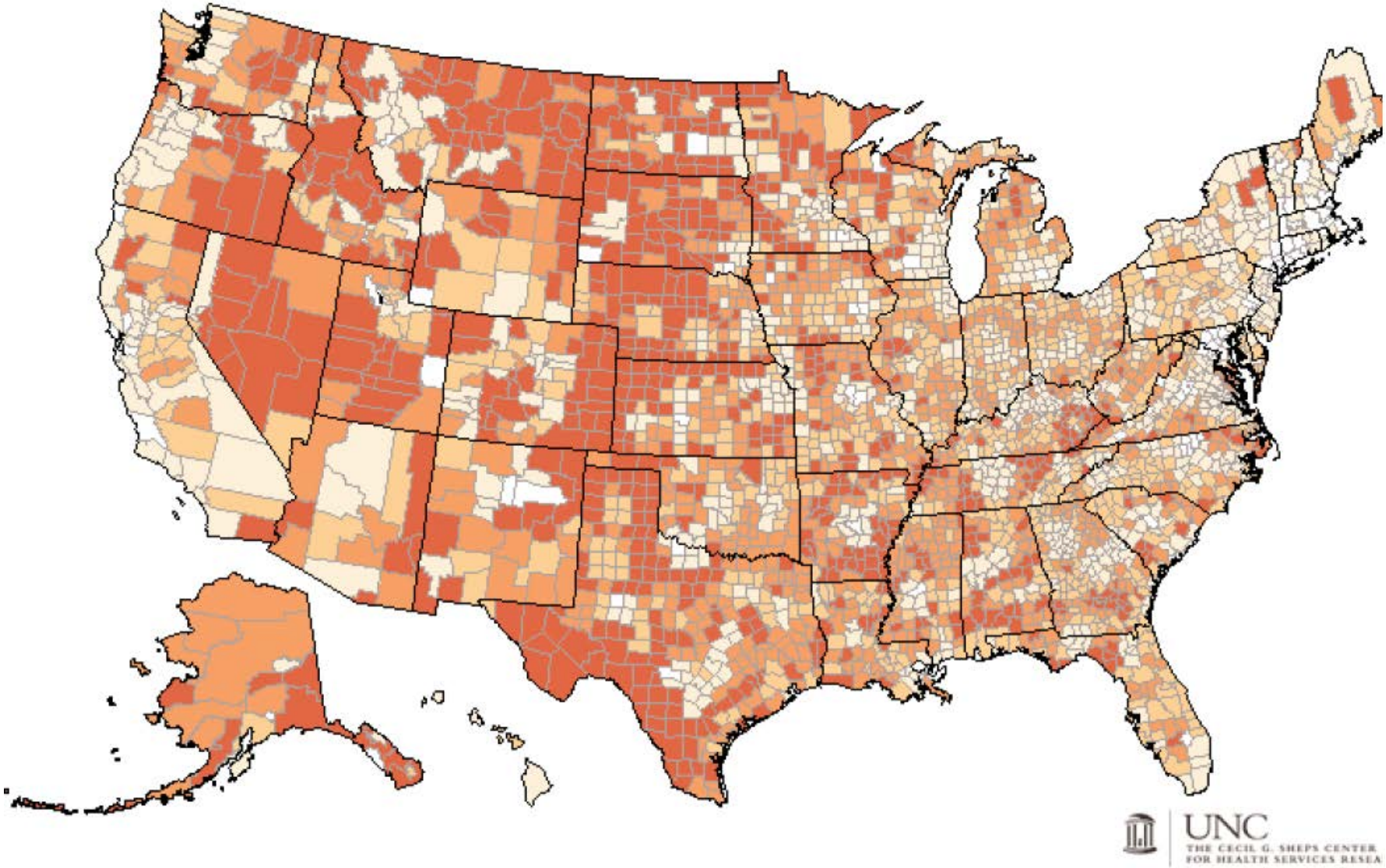
Mental Health Treatment Workforce

As described at the beginning of this section, statewide workforce FTE data is not frequently available by provider profession, service specialty, etc. But some estimates of the need for mental health professionals, especially psychiatrists who are known to be in short supply, have been calculated through individual research studies. In addition, Wisconsin's Office of Primary Care is responsible for tracking health care professional shortages in the state including psychiatrists and coordinating federal grants targeted to address these shortages.

A series of articles in 2009 examined mental health professional supply and shortage problems by county across the nation[71-73]. One article examined the unmet need for mental health professionals including psychiatrists, psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. Unmet county-level need was measured by estimating the prevalence of serious mental illness (SMI) and provider time needed by individuals both with and without SMI. The county-level unmet need is illustrated in the map on the following page.

Over three-quarters (77%) of U.S. counties had a severe shortage of either psychiatrists or other professionals, meaning over half their need was unmet. Eight percent of U.S. counties had a

Unmet Need For Mental Health Professionals Among Counties With An Overall Shortage
(Shading conveys unmet need in quartiles. The darkest shaded counties have the greatest unmet need)



52

severe shortage of nonprescribing mental health professionals and 18% of counties in the nation had at least some unmet need for nonprescribers. Much of the unmet need is with psychiatrists. Seventy- seven percent of U.S. counties had a severe shortage of psychiatrists and 96% had at least some unmet need for psychiatrists. Rural counties and those with low per capita income tended to have higher levels of unmet need.

Wisconsin counties followed this pattern. The counties with the greatest overall need for any mental health professionals were Menominee, Crawford, Richland, Sauk, Adams, Marquette, Buffalo, Clark, Taylor, Price, Iron, Sawyer, Washburn, and Burnett - all mostly rural counties. All of these counties had rates of unmet need for mental health professionals that put them in the top quartile nationally for unmet need. Most other counties with similarly high levels of unmet need are found in the Great Plains, Rocky Mountains, or Alaska. Wisconsin counties in the lowest quartile nationally were primarily in the southeast area extending from Kenosha to Dane to Brown County.

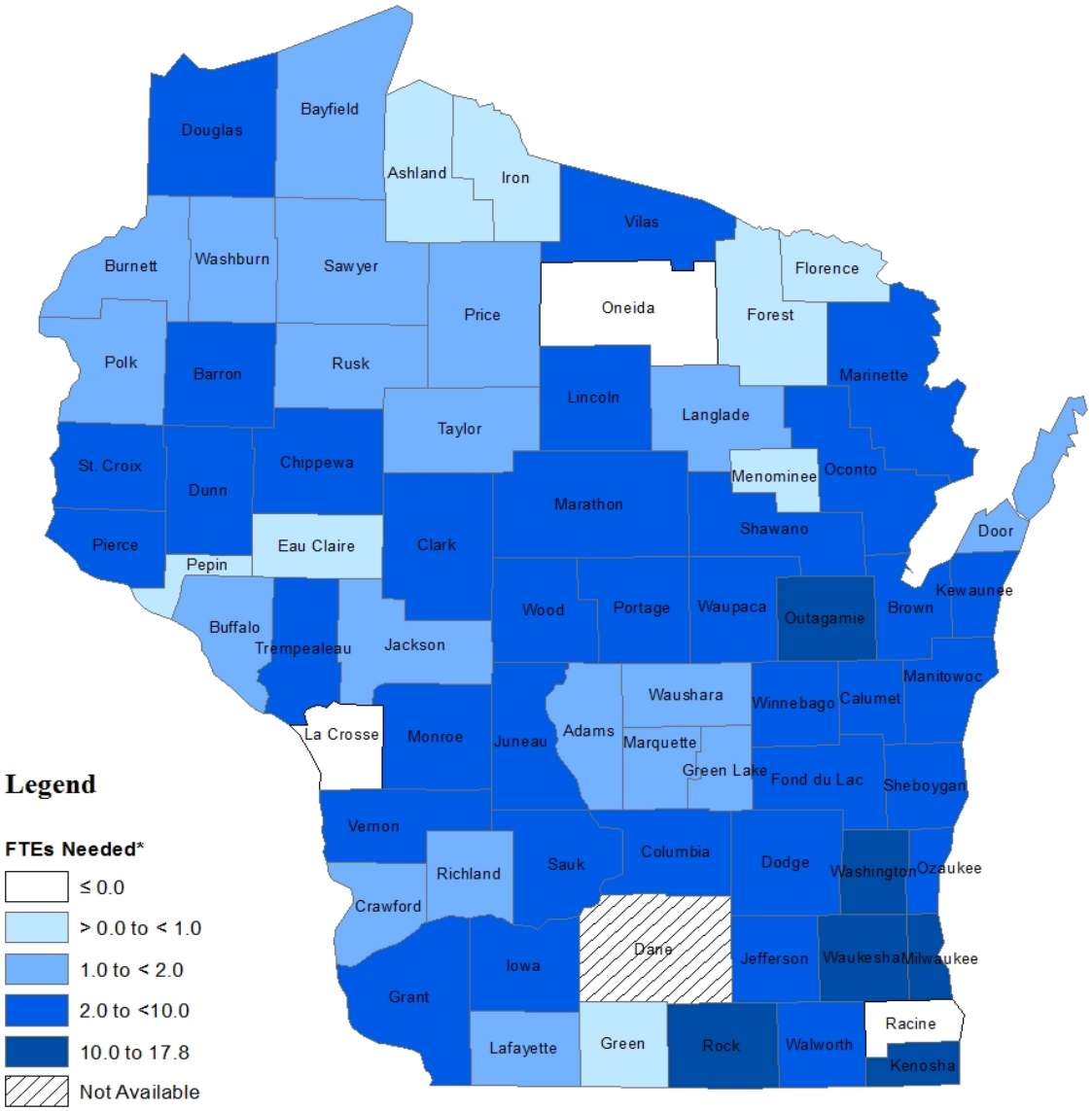
Wisconsin's Office of Primary Care within the Division of Public Health provides more detailed data on psychiatrist shortages within Wisconsin counties through its own data collection efforts from 2009-2012[74]. The map and table on the following three pages provide specific information about psychiatrist shortages in Wisconsin counties and how many are needed to eliminate the shortages. A significant shortage means having a ratio of 10,000 population to 1.0 FTE psychiatrist or higher. A 20,000 to 1.0 FTE ratio is required to qualify for a federal designation as a Health Professional Shortage Area (HPSA) and be eligible for federal benefits. Both designations are listed in the following table. Counties who are not eligible for a HPSA designation status either do not meet the population to psychiatrist ratio or are contiguous to a county with adequate psychiatrists they could access.

All but four counties (including Dane) have some level of psychiatrist shortages. Eight primarily rural counties have shortages of less than 1.0 FTE and six primarily urban counties have shortages of 10 FTE's or more. Also noteworthy for prioritizing state psychiatrist needs is that the following 16 counties reported 0 psychiatrist FTEs providing on-site outpatient care:

- Buffalo,
- Burnett,
- Chippewa,
- Florence,
- Forest,
- Green Lake,
- Iron,
- Kewaunee,
- Lincoln,
- Pepin,
- Price,
- Richland,
- Rusk,
- Trempealeau,
- Washburn, and
- Waupaca.

Number of Psychiatrist FTEs Needed to Reduce Significant Shortages for the Resident Population

November, 2012



* Data definitions and limitations in notes/table.

Wisconsin Department of Health Services
Division of Public Health
Wisconsin Primary Care Office
http://www.dhs.wisconsin.gov/health/primarycare/index.htm

Number of Psychiatrists Needed to Reduce Significant Shortage

County	# Psychiatrist FTEs * needed to reduce sig. shortage	Resident Civilian Population	Mental Health HPSA status (as of June 2012)
Wisconsin	N/A	5,486,658	
Adams	1.8	19,646	County
Ashland	0.6	15,541	Not elig – # psych
Barron	2.3	45,396	County
Bayfield	1.4	14,655	County
Brown	8.5	236,714	Not elig - # psych
Buffalo	1.4	13,657	Not elig - contiguous
Burnett	1.5	15,380	County
Calumet	4.6	47,493	Not elig – contiguous
Chippewa	6.0	60,292	Not elig - contiguous
Clark	3.2	33,933	County
Columbia	4.6	54,387	County
Crawford	1.3	16,056	County
Dane **	0.0	464,510	Not elig - # psych
Dodge	5.5	81,526	County
Door	1.9	27,724	County
Douglas	4.0	42,189	County
Dunn	3.2	39,849	County
Eau Claire	0.7	92,416	Not elig - # psych
Florence	0.5	4,511	County
Fond du Lac	3.0	98,347	Not elig - # psych
Forest	0.9	9,215	County
Grant	4.0	46,753	County
Green	0.3	35,984	Not elig - # psych
Green Lake	1.9	19,036	Not elig - contiguous
Iowa	2.1	23,449	County
Iron	0.6	5,840	County
Jackson	1.3	18,871	County
Jefferson	5.6	80,253	County
Juneau	2.5	26,600	County
Kenosha	10.5	160,047	Not elig - contiguous
Kewaunee	2.0	20,369	County
La Crosse	**-0.7**	107,543	Not elig - # psych
Lafayette	1.4	16,577	County
Langlade	1.2	19,775	County
Lincoln	2.9	28,553	County
Manitowoc	7.2	80,370	County
Marathon	9.5	130,865	County
Marinette	2.7	40,112	County

Number of Psychiatrists Needed to Reduce Significant Shortage (continued)

County	**# Psychiatrist FTEs * needed to reduce sig. shortage**	**Resident Civilian Population**	**Mental Health HPSA status** (as of June 2012)
Marquette	1.3	15,324	County
Menominee	0.2	4,251	County
Milwaukee Inner City **	17.8	350,243	Inner City**
Monroe	4.1	43,524	County
Oconto	3.5	37,280	County
Oneida	**-0.1**	35,415	County
Outagamie	10.2	171,629	Not elig - contiguous
Ozaukee	4.1	84,941	Not elig - contiguous
Pepin	0.7	7,336	County
Pierce	3.6	37,791	Not elig - contiguous
Polk	1.9	43,821	County
Portage	4.4	65,720	Not elig - contiguous
Price	1.4	14,156	County
Racine Inner City **	**-4.5**	19,261	Inner City**
Richland	1.8	18,002	County
Rock	10.2	156,695	Beloit & Janesville
Rusk	1.5	14,531	County
Saint Croix	7.2	81,763	Not elig - contiguous
Sauk	4.5	60,179	County
Sawyer	1.3	16,277	County
Shawano	3.4	40,957	County
Sheboygan	7.3	111,879	Being reviewed
Taylor	1.9	20,333	County
Trempealeau	2.8	27,869	County
Vernon	2.5	28,969	County
Vilas	2.1	21,553	County
Walworth	8.2	98,813	County
Washburn	1.5	15,042	County
Washington	10.1	129,170	Not elig - contiguous
Waukesha	22.9	381,495	Not elig - contiguous
Waupaca	5.1	50,725	County
Waushara	2.0	23,248	County
Winnebago	2.2	155,133	Not elig - # psych
Wood	2.9	73,782	Not elig - # psych

** Data is incomplete for these counties except for the inner city areas of Milwaukee and Racine.

Status of Efforts to Increase Capacity

An annual survey of Wisconsin's 72 Community Support Programs (CSP's) includes questions about the use of waitlists. The State DHS allocates $1 million dollars annually to CSP's to help relieve these waitlists, although the funding is not enough to eliminate them. While some of the consumers put on the waitlists received other services while they waited, the waitlist totals are a good indicator of the size of the gap in capacity for CSP's specifically. Twenty (28%) of the 72 CSPs reported the use of waiting lists in 2011 for participants they could not actively serve[75]. There were 422 participants on these waitlists at some time during 2011, an increase of 100 people over 2010. Programs reported that the average time on their CSP waitlist for consumers was 6 months. The table below describes which counties had inadequate capacity in their CSPs ranked by number of consumers on their waitlist in 2011. The actual additional CSP slots needed per county may be slightly less than the figures below which represent total consumers who may could be removed from the list and replaced by another consumer during the year.

Community Support Program Capacity Needs in 2011

County	**Total CSP Consumers on the Waitlist 2011**
Jackson	1
Lafayette	5
Clark	6
Rock	6
Bayfield	9
Forest, Oneida, Vilas	12
Racine	12
Green	13
Monroe	15
Vernon	17
Sheboygan	23
Polk	25
Columbia	26
Waukesha	27
Ashland	28
Sawyer	33
Dane (2 CSP's)	40
Sauk	43
Kenosha	81
TOTAL	**422**

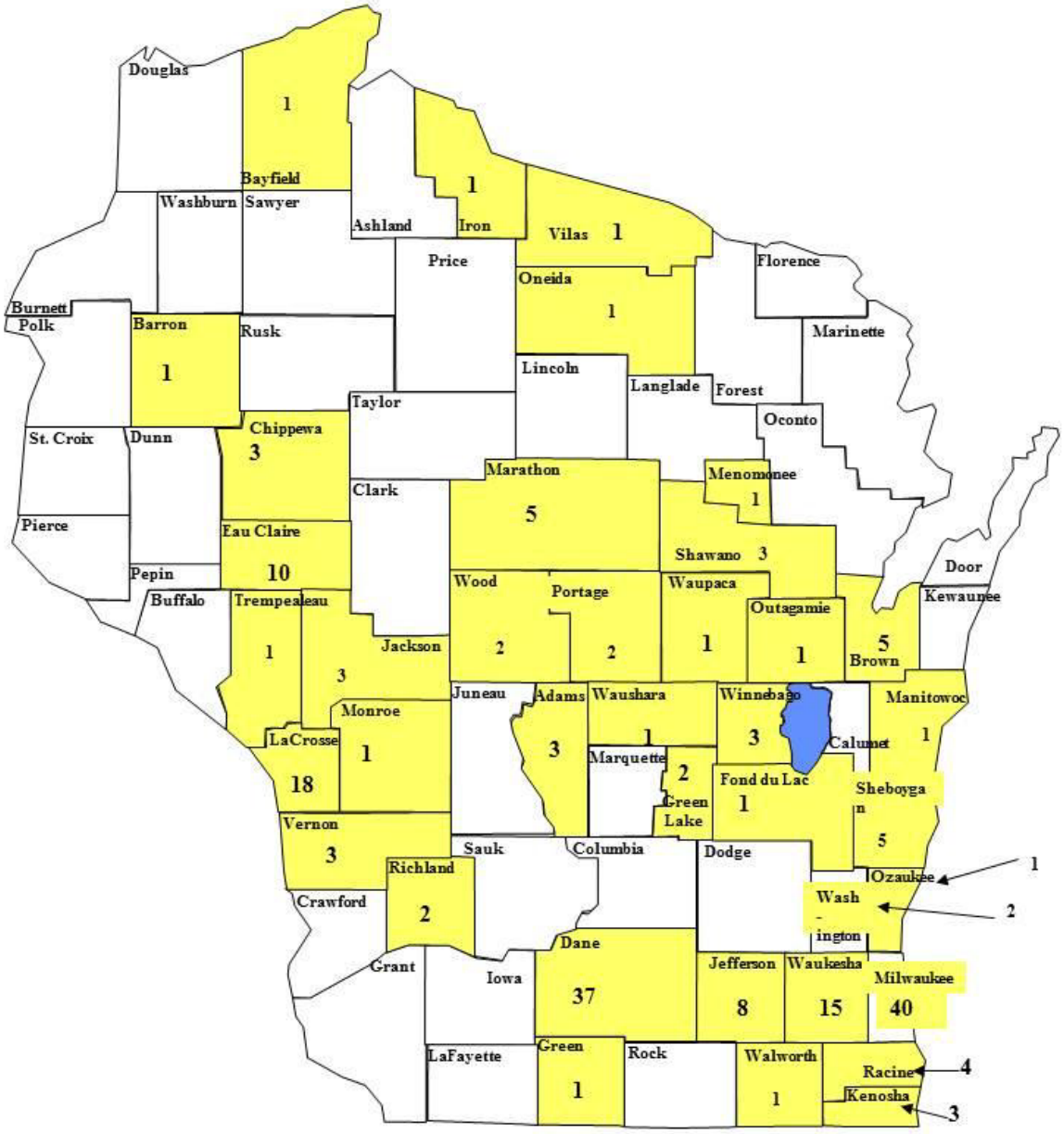
Inadequate workforce capacity can sometimes be due to a geographical mismatch between available workers and consumers in need. The use of TeleHealth in Wisconsin since 2007 has been increasing to help address this need. As described above, psychiatry services in particular are lacking in many rural areas, but may be in surplus in some urban areas such as Dane County. The table below describes the number of TeleHealth certifications in 2012 for an array of MH/AODA services[76]. The number of providers offering TeleHealth is less than the 113 certifications as some providers are certified to provide multiple TeleHealth services. TeleHealth is used approximately twice as much for mental health services compared to substance abuse services. Although there's room for expansion among all services, TeleHealth seems to be currently used more often for regular outpatient services and less for emergency/crisis services and psychosocial rehabilitation programs (CCS and CSP). Increased use of TeleHealth in CSP's could potentially be part of the solution to relieving the waitlist issue described above.

Number of MH/AODA TeleHealth Certifications 2012

Type of Service	**# of Certifications**
DHS 35 MH Outpatient	46
DHS 40.11(2)(a-c) Children's Day Treatment	13
DHS 34.3 MH Crisis	10
DHS 63 CSP	6
DHS 36 CCS	3
DHS 61.75 Day Treatment	2
DHS 75.13 AODA Outpatient	23
DHS 75.05 AODA Emergency Outpatient	6
DHS 75.12 AODA Day Treatment	2
DHS 75.14 AODA Transitional Residential	1
DHS 75.04 AODA Prevention	1
Statewide Total	**113**

Although the initiative in Wisconsin is still relatively young, the number of peer specialists being trained to join the mental health workforce has been steadily increasing through efforts by the Department of Health Services. Peer specialists can not only increase the capacity of an agencies work force, they can also improve the quality and effectiveness of treatment by establishing a collaborative, trusting relationship between the provider agency and the consumer. Work needs to be done to better connect certified peer specialists to mental health programs, educate prospective mental health agencies as to the value of peer specialists, and distribute peer specialists to cover a larger portion of the state. However, a 2011 survey found that all but 17 of the 114 certified peer specialists at the time were employed somewhere[77]. Below is a map showing the geographic locations of the trained and certified peer specialists illustrating which parts of the state could improve their workforce capacity by adding peer specialists.

Certified Peer Specialists by County as of September 2012



XXXX Certified Adult Mental Health Peer Specialists as of September 2012 = 193

- CPSs whose certification lapsed before Sept. 2012 have been taken out.

Providers' Assessment of Their Own Capacity Needs

What do providers believe are the greatest needs when it comes to their capacity to meet the demand for MH/AODA services? Providers are the people who determine who will be enrolled immediately and who will be placed on a waiting list or turned away altogether. Providers must determine which programs or services are appropriate and available to meet consumers' needs. In 2009, The Management Group, Inc. conducted a study for the Department of Health Services examining the MH/AODA service system infrastructure which included such a provider assessment of unmet capacity needs[78]. Nine county service areas were selected for interviews to provide a representative sample of the state's 67 public MH/AODA service systems. Providers assessed the following areas of the MH/AODA service systems to have the greatest unmet need:

- Outpatient services
    - Psychiatrist and nurse time, especially to prescribe and manage medications
    - Child psychiatry services
    - Wait times of up to 3-6 months
    - Limited choice for indigent consumers
    - Providers willing to accept Medicaid reimbursement rates
- Crisis services
    - Mobile crisis services
    - Timely follow-up to crisis
    - Crisis beds
    - Crisis diversion beds for those with substance abuse issues
- Inpatient services
    - Community inpatient capacity
    - Alternative inpatient facility that is less costly than the state mental health institutes
- Substance abuse services
    - Service capacity for those with painkiller addictions
    - Cognitive behavioral element in substance abuse treatment
- Early intervention and prevention services.
- Support services (e.g., vocational, peer support) to help avoid treatment and crisis.
- Services for those with less persistent and serious mental illness (i.e., those lower on the priority list).
- Services for those that are dually diagnosed with mental health, physical health and substance abuse issues, especially those addicted to pain medication.
- Services for nursing home residents with dementia and behavioral issues that cannot be safely managed in a nursing home setting.

IV. ARE WISCONSIN'S MH/AODA SERVICES EFFECTIVE?

So far, we've examined the prevalence of MH/AODA needs, consumers' access to services, and the capacity of our MH/AODA workforce and service systems to meet consumers' needs. However, even when qualified MH/AODA workers are available and consumers successfully access services, there is still no guarantee that consumers' needs will be met.

The purpose of this section is to examine to what degree consumers are treated effectively in Wisconsin's MH/AODA service system. Three broad areas will be examined:

1. QUALITY AND APPROPRIATENESS OF SERVICES
2. CONSUMER OUTCOMES
3. IMPACT
4. OTHER STAKEHOLDER INPUT ABOUT SERVICE NEEDS

Once consumers access services, many factors can influence whether consumers' needs have been met before being discharged from treatment. Services provided to consumers must be appropriately matched to their specific needs and services must be delivered in a quality manner according to treatment standards and using best practices when possible. Needs and gaps in the areas of quality and appropriateness are important to examine because they sometimes can be more readily addressed through the addition of training components for staff.

Ultimately, the effectiveness of services must be assessed based on the outcomes of the service experience for the individual consumer. Consumer outcomes, such as reduction in alcohol use and employment status, are examined. An epidemiological approach is used to examine broad system and societal impacts such as hospitalization rates and alcohol-related traffic deaths.

Lastly, we provide a summary of important input from consumers and Tribal Nations.

1. Quality and Appropriateness of Services

Some important issues related to the quality and appropriateness of services received by consumers examined in this section include:

- Are evidence-based practices (EBP's) used to deliver quality services with proven effectiveness?
- Are services delivered in a Recovery-based manner?

The Use of Evidence-Based Practices

Substance Abuse Prevention

The use of evidence-based prevention approaches has been evolving slowly. It wasn't until 2007 that the Federal government provided an accessible listing of evidence-based prevention programs called the National Registry of Evidence-based Programs and Practices (NREPP). Finding a national study on the utilization of evidence-based prevention approaches has been challenging. Prior to the availability of the Federal NREPP listing, a survey was conducted in 2005 of a nationally representative sample of 1,721 schools with middle school grades and having drug prevention programs. The survey found that 42.6% of the nation's schools with middle school grades and drug prevention programs were using an evidence-based curriculum and the use of evidence-based approaches appears to be growing.[79]

According to the 2011 Substance Abuse Prevention Services Information System (SAPSIS) there are a reported 267 substance abuse prevention programs of various types across Wisconsin. While data may be available from several states using the Knowledge-based Information Technology (KIT) system, obtaining comparable national data is not possible at this time. However, we were able to obtain comparable data for 2011 from the state of Oregon's prevention Minimum Data Set. Oregon's data represents 1,362 prevention programs. The table that follows shows the percent of prevention programs targeting various populations. Wisconsin is generally comparable to Oregon although Wisconsin prevention programs target more persons already using substances and fewer economically disadvantaged populations (see the table below).

Programs Targeting Substance Use Prevention Populations

Population Targeted	Percent of Prevention Programs	
	Wisconsin (n=267)	**Oregon** (n=1,362)
Victims of physical, emotional or sexual abuse	1.5%	Less than 1%
Persons already using substances	11.6%	6.2%
Children of substance abusers	2.6%	1.1%
High school dropouts	Less than 1%	1.1%
Economically disadvantaged persons	10.1%	25.3%
General population of children, youth and adults	66.3%	64.7%
Homeless persons in general including or runaway youth	Less than 1%	Less than 1%
Persons with mental health issues	2.2%	Less than 1%
Pregnant females, all ages	1.1%	Less than 1%
Juvenile delinquents	3.4%	Less than 1%
Total	100%	100%

Substance Abuse Treatment

Treatment service quality can be analyzed by looking at whether or not services meet good clinical and safety standards, utilize evidence-based approaches or other proof that clients are satisfied with services, consider service right for them, and report that they are benefitting from services.

All Wisconsin substance abuse service providers receiving State or County funds (estimated at 140) must meet minimum clinical and safety standards set down in law. However, data are not readily available on provider violations, citations, suspensions or terminations issued.

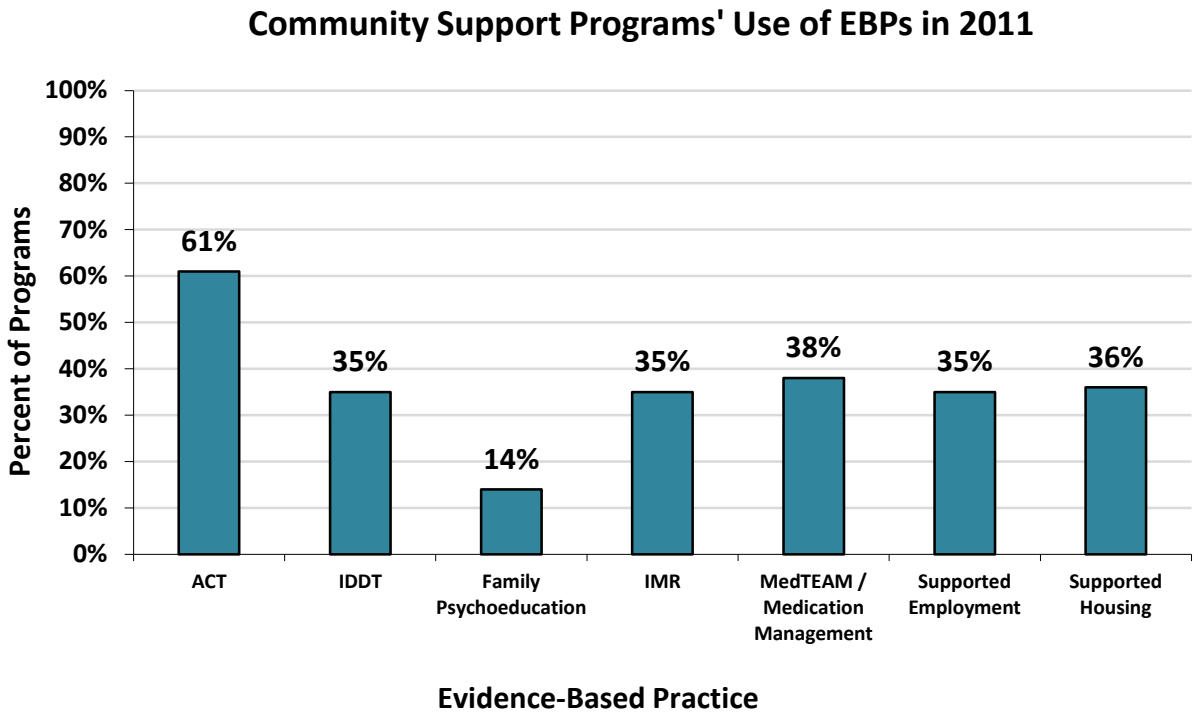
While the use of evidence-based practices and client satisfaction are on the list of priorities among stakeholders, Wisconsin-specific substance abuse data on these areas is currently unavailable. National studies suggest that the vast majority (70%) of addiction treatment counselors would agree that it is good practice to use treatment approaches proven by research. However, only 40% may actually use evidence-based practices. Barriers include lack of time or funds, lack of administrative support, insurance restrictions, and potential client resistance. What's equally important is collecting and using data on treatment effectiveness in order to "prove the practice".[80-82]

Mental Health

One of the federal Mental Health Block Grant reporting requirements for all states is to report on their use of evidence-based practices (EBPs) which serves as an indicator of the effectiveness of states' treatment. While EBPs may potentially be used throughout Wisconsin by a variety of public and private providers, the available DHS data on county systems' use of EBPs is focused on Community Support Programs (CSPs).

The Division of Mental Health and Substance Abuse Services (DMHSAS) conducts an annual survey of all CSPs across the state. The survey has asked program staff for information on their use of EBPs since 2007. The DMHSAS provided grant funding to select counties from 2006-2008 to implement EBPs for adults and has more recently funded training for Supported Employment, but counties and CSPs have been on their own otherwise to select and implement EBPs.

Rates of EBP use by the 78 CSPs in 2011 are displayed in the chart below and were similar to those reported in 2010.[83] Of the 72 CSPs reporting in 2011, Assertive Community Treatment (ACT) was used by 61% of programs (N=44). All other EBPs such as Integrated Dual Disorder Treatment (IDDT) and Illness Management and Recovery (IMR) were used by just over a third of programs with the exception of Family Psychoeducation. Eighty-two percent of CSPs used at least one EBP with their consumers including Lafayette County, Eau Claire County, Milwaukee County Department of Health and Human Services, and Dane County's Program of Assertive Community Treatment who used six each.



Trends in the number of consumers served with EBPs over the last few years are unclear because of challenges in working with CSPs to report EBP use in a consistent manner. Trend changes in the number of consumers served with EBPs should be reliable and available in the near future.

To what degree did CSPs implement EBPs faithful to the prescribed treatment model to ensure the most effective and highest quality service was provided? CSPs were asked to report on several aspects of the implementation of each EBP including:

1. Have CSP staff been specifically trained to implement this EBP?
2. Did you use the official EBP toolkits to guide your implementation?
3. Did you monitor the fidelity of your implementation?
4. Did you use an outside monitor to review fidelity?

The first issue of quality treatment provision within CSP's is to what degree they have implemented the ACT model on which CSPs are based. Of the 44 CSPs who used ACT, 86% have trained their staff on ACT in some way. However, just over half of these CSPs have used the official ACT implementation toolkit or monitored the fidelity of their implementation. Most programs have monitored their own fidelity as opposed to enlisting an independent outside monitor. Thus, the primary quality issue for CSPs worth further examination is what type of treatment is being provided by the 39% of CSPs that are not using the ACT model. For those using ACT, more emphasis may be needed on using the official ACT implementation toolkit including its fidelity measures. The same pattern of implementation exists for the other EBPs used among CSPs as well.

ACT Implementation within CSPs in 2011 (N=44)

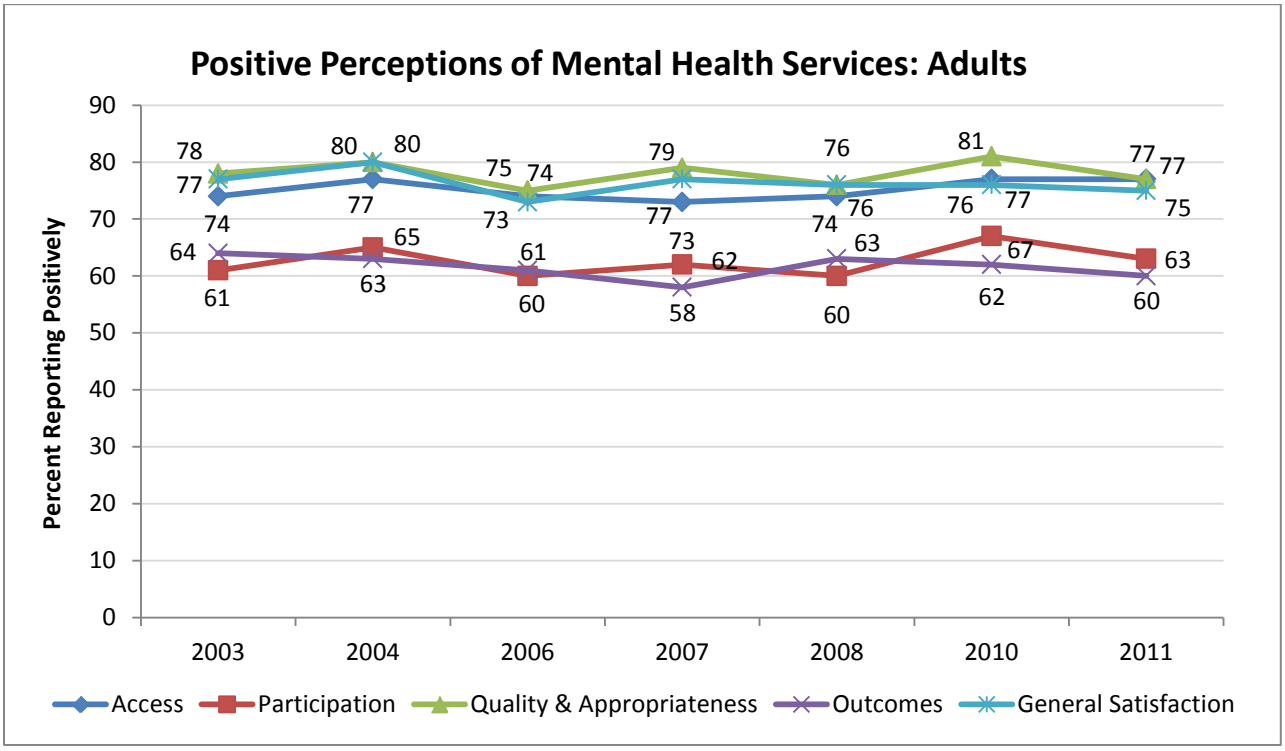
Implementation Step	% of CSPs
1. Staff Trained	86%
2. EBP Toolkits Used	57%
3. Monitored Fidelity	52%
4. Outside Monitor Used	14%

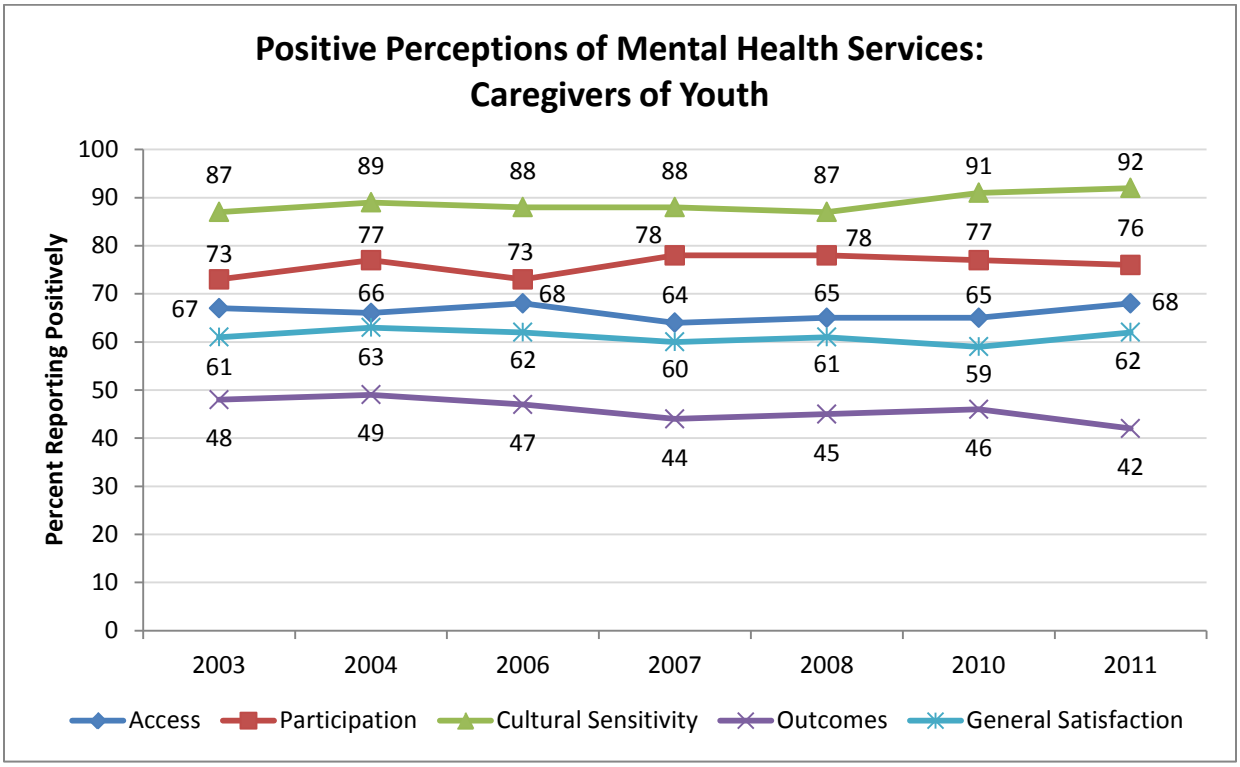
Consumer Satisfaction with Mental Health Treatment Quality

Although the CSP survey is completed by providers, consumer input is also available to assess the quality of mental health services delivered across the state. Consumer input is a better source for understanding how he/she was treated during their service experience. Whether the consumer was treated with respect, involved as an equal partner in establishing their treatment plan and goals, treated with respect to their cultural heritage and other specific individual needs, etc., are assessments that are best made from the consumer's perspective.

As a result, the DMHSAS distributes a satisfaction survey to consumers of public mental health services across the state every year. A random sample of adult and youth consumers with serious mental illness or severe emotional disorders (SMI/SED) is surveyed. For youth 6-17 years old, the primary caregiver completes the survey about their satisfaction with their child's mental health services. For analyses, satisfaction questions are grouped into scales corresponding to several areas (or "domains") of satisfaction including general satisfaction,

quality and appropriateness, access, participation in services, and functional outcomes. Questions are not the same between the adult and youth surveys. Trends and individual question responses are displayed in the charts on the following two pages.[84]





2011 Adult Mental Health Consumers' Satisfaction with Services

	Strongly Disagree	Disagree	Un-decided	Agree	Strongly Agree
PARTICIPATION IN TREATMENT PLANNING					
I felt comfortable asking questions about my treatment and medication.	5%	6%	9%	43%	37%
I, not staff, decided my treatment goals.	6%	11%	18%	37%	29%
QUALITY AND APPROPRIATENESS OF SERVICES					
Staff believed that I can grow, change and recover.	4%	6%	19%	39%	34%
I felt free to complain.	6%	7%	19%	37%	31%
I was given information about my rights.	4%	4%	6%	40%	46%
Staff encouraged me to take responsibility for how I live my life.	4%	5%	14%	46%	31%
Staff told me what side effects to watch out for.	4%	10%	16%	40%	30%
Staff respected my wishes about who is and is not to be given information about my treatment.	3%	3%	10%	42%	42%
Staff was sensitive to my cultural background.	4%	4%	12%	43%	38%
Staff helped me obtain the information I needed to take charge of managing my illness.	6%	6%	15%	43%	30%
I was encouraged to use consumer-run programs.	5%	13%	13%	40%	30%

2011 Caregivers' Satisfaction with Youth Mental Health Services

	Strongly Disagree	Disagree	Un-decided	Agree	Strongly Agree
PARTICIPATION IN TREATMENT PLANNING					
I helped to choose my child's services.	6%	12%	8%	44%	30%
I helped to choose my child's treatment goals.	3%	9%	11%	47%	31%
I participated in my child's treatment.	1%	3%	6%	49%	41%
CULTURAL SENSITIVITY					
Staff treated me with respect.	1%	2%	7%	46%	44%
Staff respected my family's religious/spiritual beliefs.	1%	0%	10%	48%	42%
Staff spoke with me in a way that I understood.	0%	1%	6%	50%	44%
Staff were sensitive to my cultural/ethnic background.	>1%	>1%	6%	52%	41%

A summary of adult consumers' satisfaction with the quality and appropriateness of their treatment include:

- Adults' satisfaction with the overall quality and appropriateness of their mental health services has been relatively high compared to other areas at 75-80%. Levels of satisfaction have not varied much over time over the last eight years.
- Providing information about consumer rights, respecting who has access to consumers' information, and the cultural appropriateness of services were top-rated individual questions (over 80% satisfaction).
- A second quality-related scale measures participation in treatment planning with which 63% of adult consumers have been satisfied with consistently over time. However, that means 4 of 10 adults are consistently neutral or unsatisfied about their participation in treatment planning.
- Results from individual questions in the "participation" domain reveal that most adult consumers are satisfied with their ability to ask questions, but fewer agree that they decided on their treatment goals rather than staff.

A summary of caregivers' satisfaction with the quality and appropriateness of their child's treatment include:

- Similar to adults, the highest rated area for youth was related to quality and appropriateness. Satisfaction with the cultural sensitivity of youth services is very high at about 90% and has not changed over time.
- Caregivers were more satisfied (76-78% over the last four years) with participation in treatment planning than adult consumers were with their participation.

Although aspects of the quality of consumers' service experience were rated relatively high, it did not lead to improved functional outcomes for everyone. In 2011, 77% of adult consumers felt satisfied with the quality of their services, but only 60% were satisfied with the functional outcomes of their services. The gap for youth is even greater. In most years, 75% or more of caregivers are satisfied with the cultural sensitivity of services and their participation in treatment planning, but always less than 50% of caregivers are satisfied with the outcomes of their children's services. Although different survey methodologies used by states around the country render comparisons questionable, Wisconsin's rates of satisfaction with these areas of quality are typically 8-12% lower than the national average for both adults and children.[85]

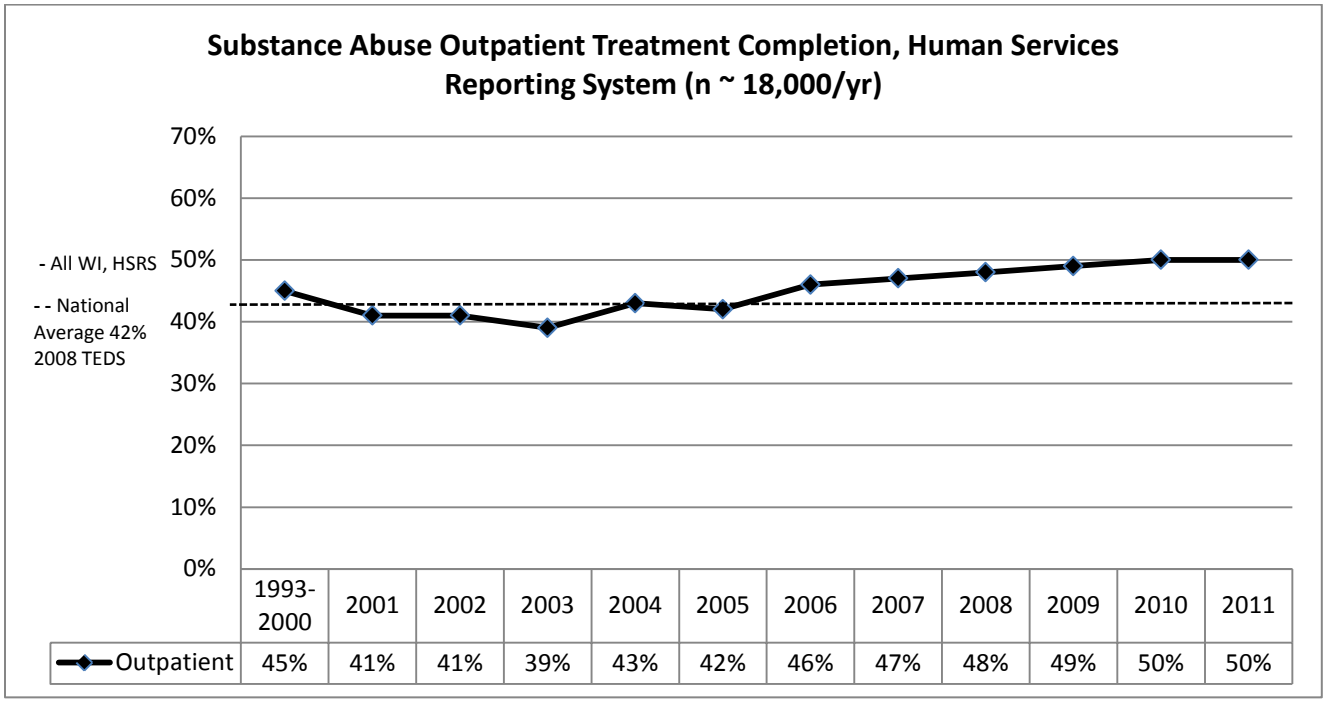
Possible disparities in satisfaction among groups have been examined in different years through special survey samples. In 2007, an oversample of minority racial and ethnic groups revealed no significant differences with Caucasians. In 2009, a special sample of consumers without an SMI/SED also revealed no significant differences with consumers who have an SMI/SED.

Other Substance Abuse Treatment Quality Indicators

Client satisfaction with services data is also not readily available for Wisconsin's addiction treatment providers although most providers collect and maintain this data in their paper files. National studies in this area generally indicate that 75% of clients have medium or high satisfaction with substance abuse services. However, studies are inconclusive as to whether

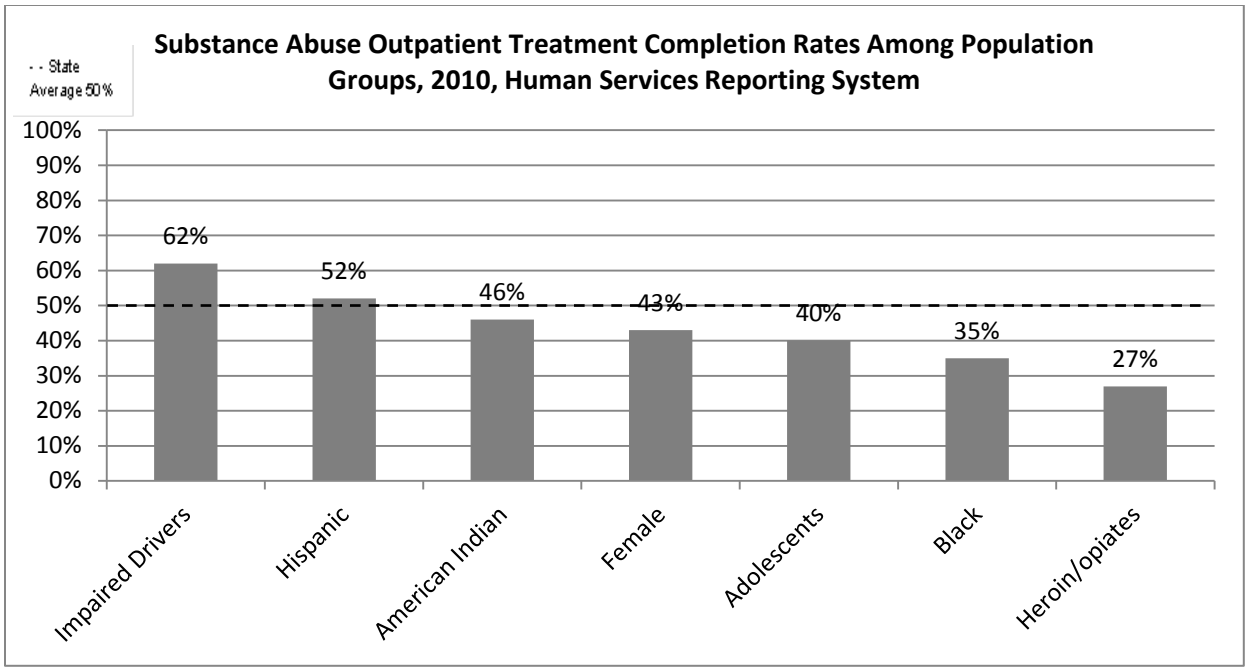
service satisfaction is correlated with improvements in quality of life, symptoms and functioning.[86,87]

Three decades of research has demonstrated that substance abuse treatment completion is strongly associated with positive post-discharge social functioning outcomes.[88-90] Therefore, one proxy indicator of the quality of services is an analysis of substance abuse treatment completion rates. The chart below tracks Wisconsin outpatient substance abuse treatment completion rates over the past 18 years. The increase seen in 2006 and the years that follow is a result of the STAR-SI quality improvement program which consists of 50 substance abuse treatment providers pursuing various quality improvement projects. The national outpatient treatment completion average in 2008, depicted by the dashed line, was 42%.



	1993-2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Outpatient	45%	41%	41%	39%	43%	42%	46%	47%	48%	49%	50%	50%

While the overall statewide rate of outpatient treatment completion in Wisconsin exceeds the national average, there are disparities that exist among several population groups for which data are available. Treatment completion rates for African Americans, American Indians, females, adolescents and heroin/opiate abusing clients are below the state average of 50% (dotted line in the following chart).

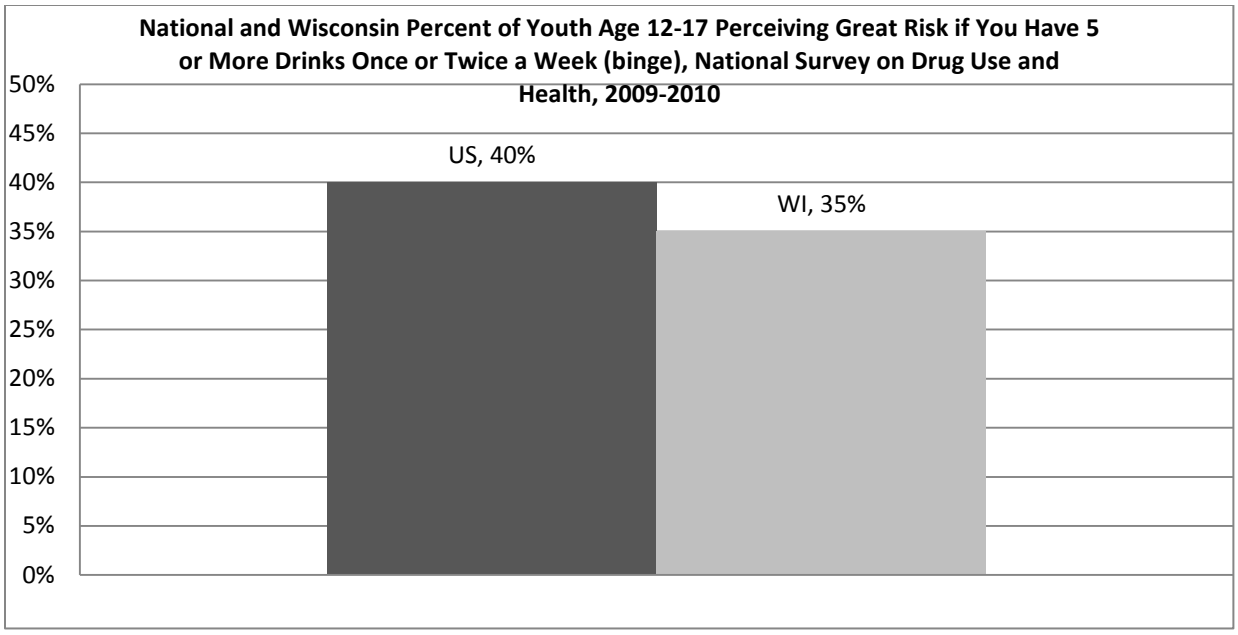

Substance Abuse Outpatient Treatment Completion Rates Among Population Groups, 2010, Human Services Reporting System
- - State Average 50%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
62%
52%
46%
43%
40%
35%
27%
Impaired Drivers
Hispanic
American Indian
Female
Adolescents
Black
Heroin/opiates

2. Consumer Outcomes

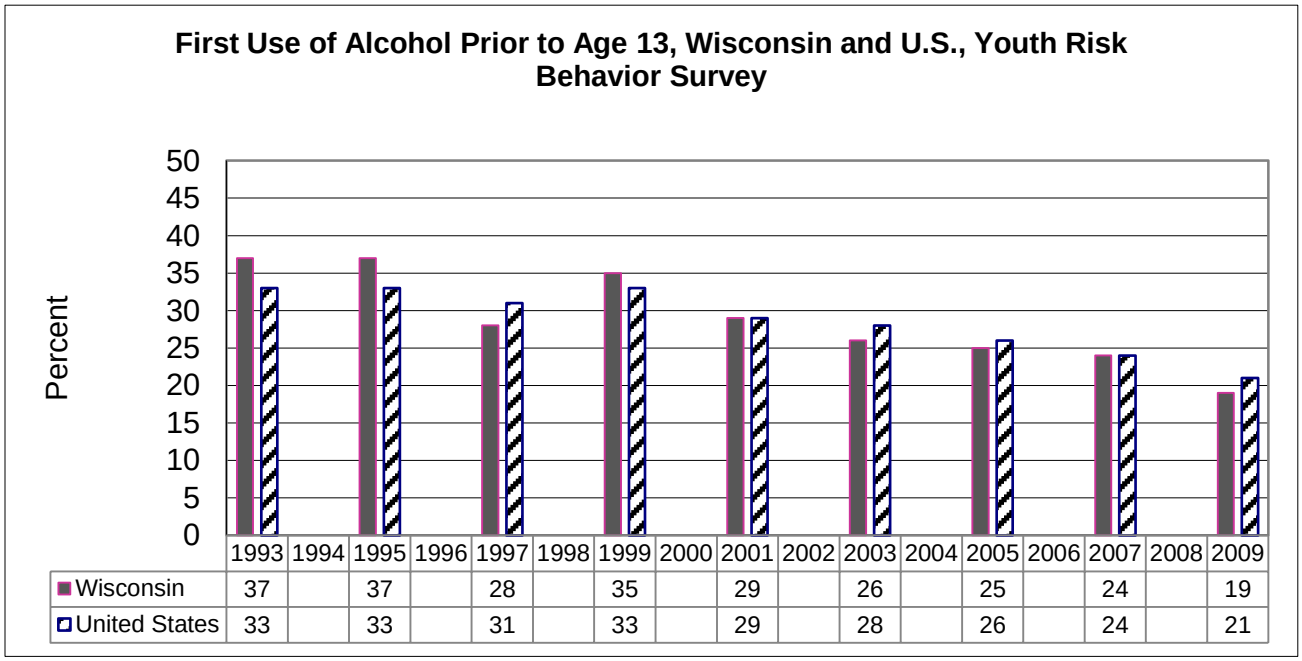
Substance Abuse Prevention

In October 2001, the State of Wisconsin was awarded a three-year, $9 million Federal grant to reduce the use and abuse of alcohol, tobacco, and other drugs among Wisconsin's 12 to 17 year-old youth. This State Incentive Grant (SIG) operated until December 2005. In November 2002, Wisconsin awarded SIG sub-grants to 17 local coalitions, with the amount of funding proportional to the youth population in the county or tribe. Each sub-recipient coalition's service area covered at least one county or tribal reservation. One of the SIG project's principal objectives was to implement universal, indirect environmental prevention strategies. An evaluation of the project found that local coalition stakeholders reported a dramatic increase in the use of environmental strategies to control youth access to alcohol including alcohol server training, drinking age enforcement education and alcohol merchant drinking age compliance checks. Use of environmental strategies for tobacco prevention followed the same pattern as did the use of these initiatives for alcohol prevention. The SIG project's impact on youth attitudes and behaviors was mixed, however, and likely due to the influence of factors outside of the project. While youth attitudes toward using alcohol or marijuana changed in a positive direction, their behaviors did not. SIG prevention activities aimed toward parents were positive and demonstrated increased family bonding, more parental involvement with and support of children, improved abilities to set and enforce rules and expectations for behavior, and greater monitoring of children.[91]

The Federal Substance Abuse and Mental Health Services Administration has identified several state-level indicators of the outcome of prevention activities which are showing positive gains for Wisconsin. While the previously discussed SIG evaluation had mixed results, there are recent signs that things are moving in a positive direction according to statewide data on hazardous binge drinking among youth. In a previous graph, the trend in binge drinking among Wisconsin youth is downward although Wisconsin is still higher than the national average. Accounting for this, the following chart shows Wisconsin below the national average on positive attitudes toward binge drinking. According to the National Survey on Drug Use and Health, 35% of Wisconsin youth perceive great risk or harm in binge drinking once or twice a week versus the national rate of 40%.

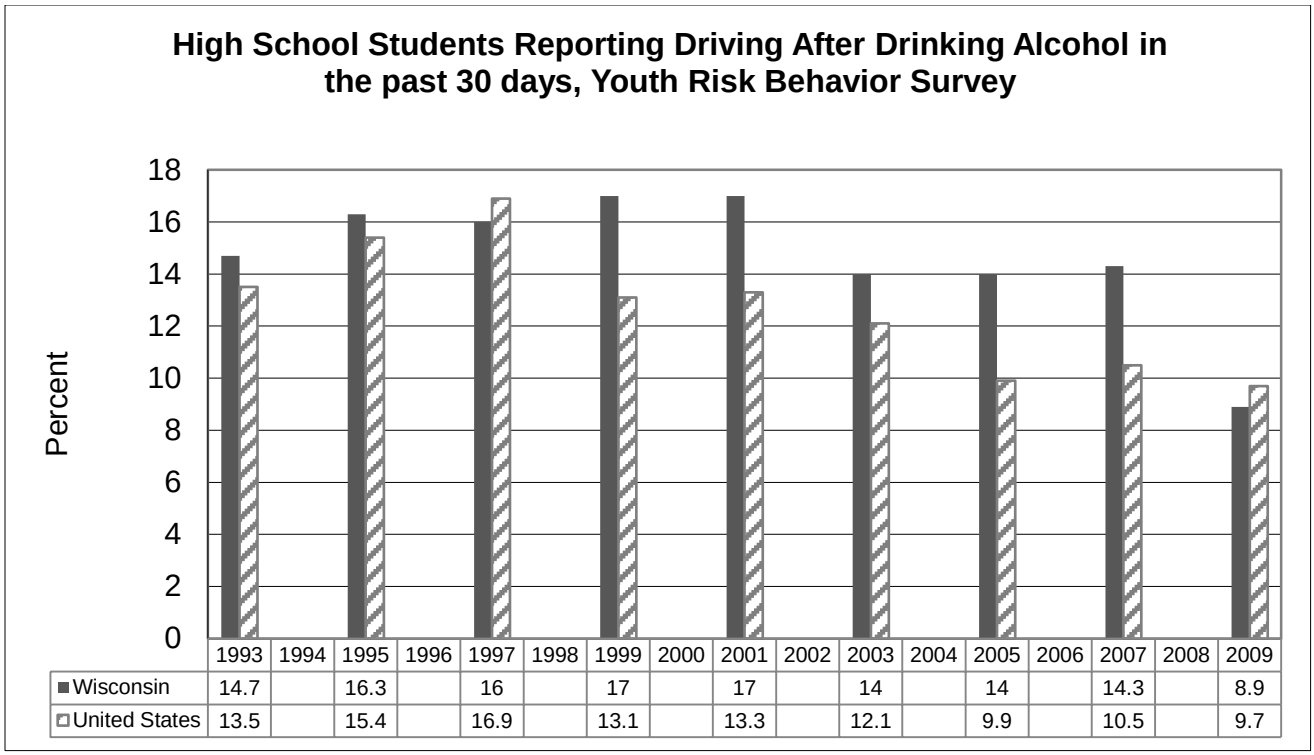


The percent of Wisconsin high school-aged youth whose 1st use of alcohol was before the age of 13 is showing a positive downward trend (see the chart below).



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Wisconsin	37		37		28		35		29		26		25		24		19
United States	33		33		31		33		29		28		26		24		21

A related prevention outcome indicator is the proportion of high school-aged youth who report driving after drinking alcohol. Obtained from the Youth Risk Behavior Survey, the chart following compares Wisconsin trends with the United States average for the past 15 years. In 2009 not only did the Wisconsin rate of youth drinking and driving go down but it also dipped below the national average for the first time in over ten years.



Substance Abuse Treatment

In the Quality and Appropriateness of Services section of this report, we presented Human Services Reporting System (HSRS; County-authorized services) data on the rate of treatment completion among persons receiving outpatient substance abuse treatment services in Wisconsin and we documented several disparities that exist in treatment completion among selected population groups. While the statewide rate of outpatient substance abuse treatment completion averaged 50% in 2011 in Wisconsin, there are ten Counties with rates well below the state average that should receive follow-up as there may be data collection, coding or service quality issues that need to be addressed.

There is additional Wisconsin outcome data from HSRS including change in substance use and change in employment status between admission to treatment and discharge. In 2011, based upon data from 19,100 outpatient treatment completers, 72% of treatment completers achieved no substance use by discharge (see table below). There was an 11 percentage point increase in the percent of treatment completers employed by the time discharge occurs.

	Percent of Clients at Admission	**Percent of Clients at Discharge**	**Percentage Point Change**
No Alcohol or Drug Use in the Past 30 Days		72%	
Employed	42%	53%	+11 points

Discharge employment rates vary among selected population groups with African American clients having disproportionately lower rates of employment at discharge (see the table below).

	Percent of Clients Employed at Discharge
African American	26%
Native American	42%
Female	45%
Hispanic	56%
State Average All Populations	53%

Mental Health Treatment

In 2011, a total of 21,309 mental health consumers were discharged from the county public system and recorded in HSRS. As a first step in examining the status of consumers at discharge, the discharge reason will be analyzed. Of these discharged consumers, 74% were categorized as having short-term situational needs as opposed to long-term serious needs. These two groups are analyzed separately in the table below to determine if there are differences in their reasons for leaving treatment.

In summary, only slight differences in status at discharge exist between consumers with long-term vs. short-term mental health needs, and much opportunity for improvement in consumer outcomes is available. Overall, 28% of consumers completed their treatment and about 20% completed after experiencing major to moderate change. Just over a quarter of both groups did not complete treatment because they were transferred or referred for further treatment elsewhere. Almost 40% of consumers with long-term needs voluntarily withdrew before completion while slightly fewer (33%) consumers with short-term needs withdrew. Also noteworthy is that consumers with more serious long-term needs were three times as likely to die while in treatment than consumers with short-term needs.

Reasons for Discharging Mental Health Consumers in 2011 (N=21,309)

	Consumers with longer-term service needs	Consumers with short-term situational service needs
Completed with major/ moderate improvement	18.8%	21.2%
Completed - no change	6.5%	7.7%
Transferred/referred	26.5%	28.5%
Withdrew before completion	39.1%	33.1%
Funding/auth. Expired	2.3%	3.6%
Incarcerated	1.5%	1.2%
Died	3.4%	1.1%
Other	1.8%	3.6%

Are outcomes better for consumers discharged from Community Support Programs which are the primary programs for consumers with serious mental health needs and based on the evidence-based Assertive Community Treatment model? While the discharge reasons for all consumers in the public system above include CSPs, they comprise a small proportion which is isolated in the results below. CSP outcomes do appear to be slightly better in some cases, but not significantly and not for all reasons. A slightly higher 26% of CSP consumers were discharged after completing treatment with improvements, but a similar percentage of consumers withdrew before completing treatment and a much higher percentage of consumers passed away while being treated in a CSP.

Reasons for Discharge from CSPs in 2011 (N=590)

Reason for Discharge	# of Participants	% of Participants
Improvements in Recovery	154	26%
Consumer Withdrew/ Moved	214	36%
Needed services beyond CSP	82	14%
Death	79	13%
Funding/Authorization Ended	11	2%
Sent to Jail	11	2%
Sent to Prison	6	1%
Other Reason	33	5%

To examine consumer outcome indicators, we can use HSRS data for mental health consumers served through the public county system. Data on functional outcomes are collected by counties by design only for consumers with more serious, long-term treatment needs. Outcome indicators examined here include employment status, suicide risk, and living arrangement. Counties are instructed to update the status of these indicators every 6 months as long as a consumer is receiving services. In 2011, a total of 5,276 consumers in the HSRS data were closed, or discharged. To examine changes from enrollment to discharge, complete data is needed at both points. In addition, enrollment and discharge data must be timely. Thus, only outcome indicators that were within 6 months of enrollment and discharge were included in the analysis. After these criteria are applied, the number of discharged consumers with complete and timely enrollment and discharge data is 1,504.

Changes in the outcome indicators from enrollment to discharge are displayed in the table below. Of the three indicators, the reduction in consumers who are a high suicide risk from 2% to 1% is the only positive change. Just over a quarter of consumers were competitively employed at enrollment which may not be unusual. A slight 1% decrease in the rate of consumers employed at discharge occurred. No change occurred in the percentage of consumers living in a private residence, but the percentage is reasonably high to begin with. Yet, room for improvement exists for this indicator as well.

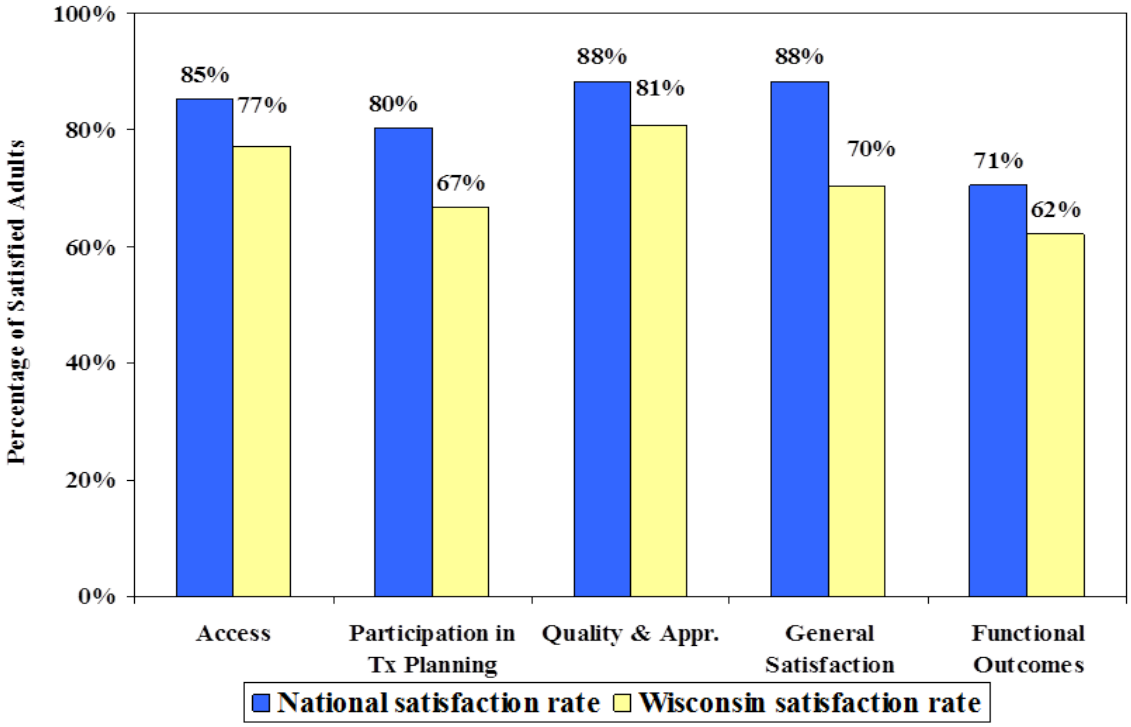
Change in Outcome Indicators for 2011 Discharged Consumers with an SMI

	Percent of Clients at Admission	Percent of Clients at Discharge	Percentage Point Change
Competitively Employed	26.7%	25.4%	-1 points
No high risk of suicide	97.6%	98.5%	+1 points
Living in private residence	85.8%	85.2%	-0.6 points

As discussed in the previous section on the quality of services, the consumer perspective is important to include in analyses as a contrast to provider-collected data which sometimes provides different results. As alluded to earlier, the annual adult and youth satisfaction surveys the DMHSAS conducts include questions about the outcomes of treatment in addition to the quality of services. A succinct way to describe the results is to combine the multiple questions on consumer outcomes into a scale score.

The consistent message from both the adult and youth satisfaction survey results annually is that satisfaction with consumer outcomes is relatively poor. Not only are levels of satisfaction about consumer outcomes lower than satisfaction with other assessed topics such as quality and participation in treatment planning, but levels of satisfaction in Wisconsin are lower than the national average as demonstrated in the chart on the following page. The differences in rates vary from 7% on quality and appropriateness scale to 18% on general satisfaction. However, the fact that Wisconsin's adult consumers rate functional outcomes the lowest of all topics is not unique. Satisfaction levels with outcomes are the lowest among consumers across the nation as well as in Wisconsin indicating the challenge of improving functional outcomes for consumers even when quality services are provided sometimes. The national comparison of youth data yields the same results for Wisconsin. In fact, caregiver satisfaction levels with the outcomes of their child's mental health services are some of the lowest in the nation (46% in 2010 and 42% in 2011). Repeating a caution stated before, states' different survey methodologies can alter the accuracy of comparing consumer satisfaction levels. While this may prevent Wisconsin's rates from being officially some of the lowest in the nation, it can also mean Wisconsin's satisfaction rates are relatively low and worthy of follow-up.

Wisconsin and National Adult Satisfaction Levels with Services - 2010



Examining individual survey question results can help us understand the greatest areas of need. The individual questions that comprise the outcomes and general satisfaction scales for adult and youth are listed on the following page with 2011 survey results. Less than 60% agree that they did better in social situations or at school/work as a result of their mental health services. For youth consumers, caregivers would like to see them get along better with family members more and be able to cope better when things go wrong as a result of mental health services. Forty percent or less of caregivers were satisfied with these two individual questions.

2011 Adult Mental Health Consumers' Satisfaction with Services

	Strongly Disagree	Disagree	Un-decided	Agree	Strongly Agree
GENERAL SATISFACTION WITH SERVICES					
I like the services that I received.	4%	7%	10%	43%	37%
If I had other choices, I would still get services from this agency.	8%	6%	13%	35%	38%
I would recommend this agency to a friend or family member.	6%	6%	13%	37%	38%
OUTCOMES					
I deal more effectively with daily problems.	3%	7%	18%	47%	24%
I am better able to control my life.	4%	9%	18%	44%	25%
I am better able to deal with crisis.	5%	9%	22%	42%	22%
I am getting along better with my family.	4%	11%	16%	43%	26%
I do better in social situations.	4%	14%	22%	40%	19%
I do better in school and/or work.	5%	14%	26%	35%	20%
My housing situation has improved.	7%	11%	19%	42%	22%
My mental illness symptoms are not bothering me as much.	6%	15%	18%	42%	20%

2011 Youth Mental Health Consumer Caregivers' Satisfaction with Services

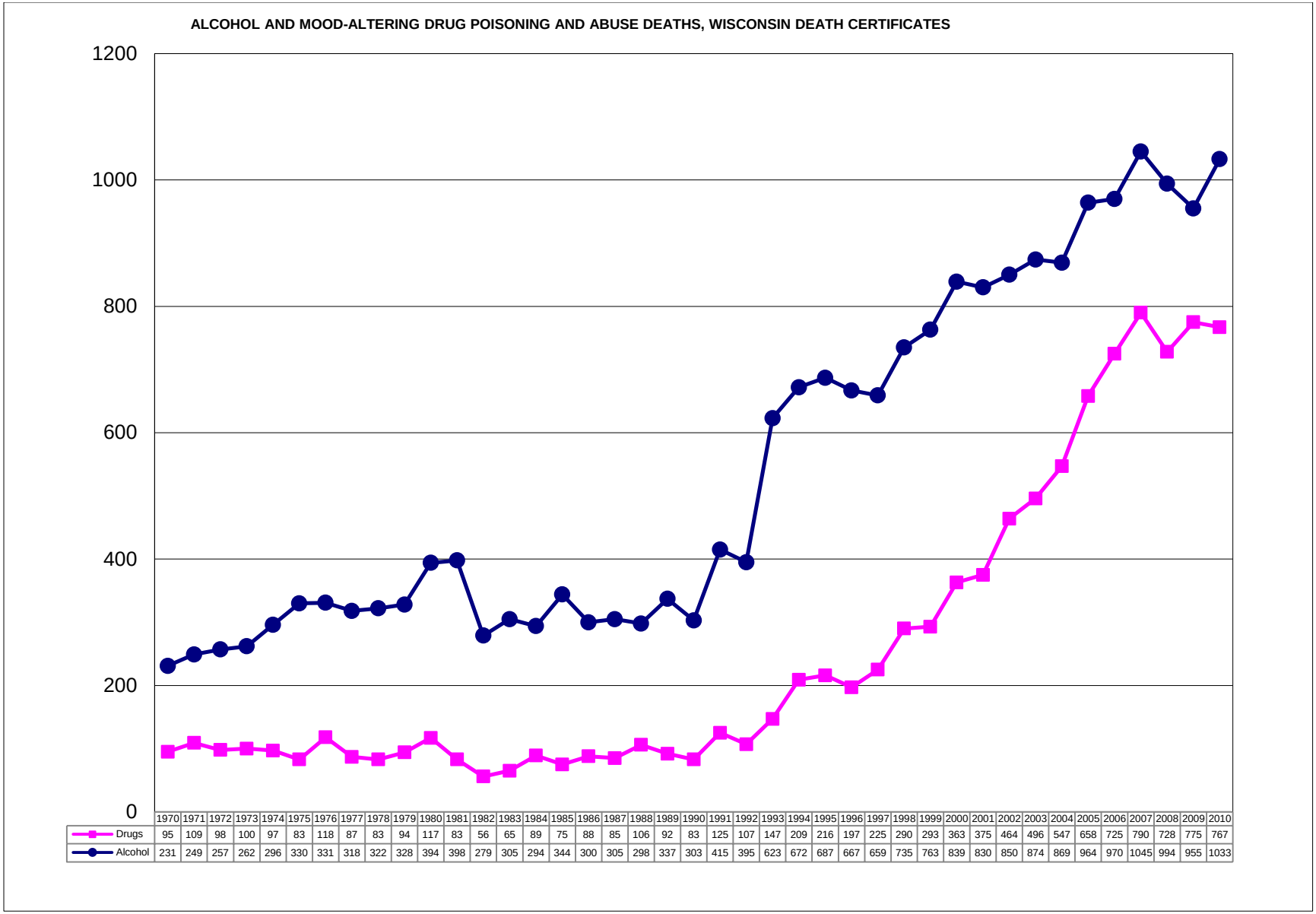
	Strongly Disagree	Disagree	Un-decided	Agree	Strongly Agree
GENERAL SATISFACTION WITH SERVICES					
Overall, I am satisfied with the services my child received.	3%	9%	15%	48%	26%
The people helping my child stuck with us no matter what.	4%	6%	15%	39%	37%
I felt my child had someone to talk to when he/she was troubled.	3%	11%	18%	39%	29%
The services my child and/or family received were right for us.	1%	3%	6%	49%	41%
My family got the help we wanted for my child.	5%	12%	22%	38%	23%
My family got as much help as we needed for my child.	6%	16%	26%	31%	21%
IMPROVEMENT IN FUNCTIONING					
My child is better at handling daily life.	4%	18%	27%	36%	16%
My child gets along better with family members.	5%	17%	36%	27%	14%
My child gets along better with friends and other people.	2%	14%	29%	42%	13%
My child is doing better in school and/or work.	5%	19%	19%	38%	19%
My child is better able to cope when things go wrong.	5%	21%	31%	22%	10%
My child is better able to do things he or she wants to do.	2%	18%	25%	45%	10%

3. Impact

Substance Abuse

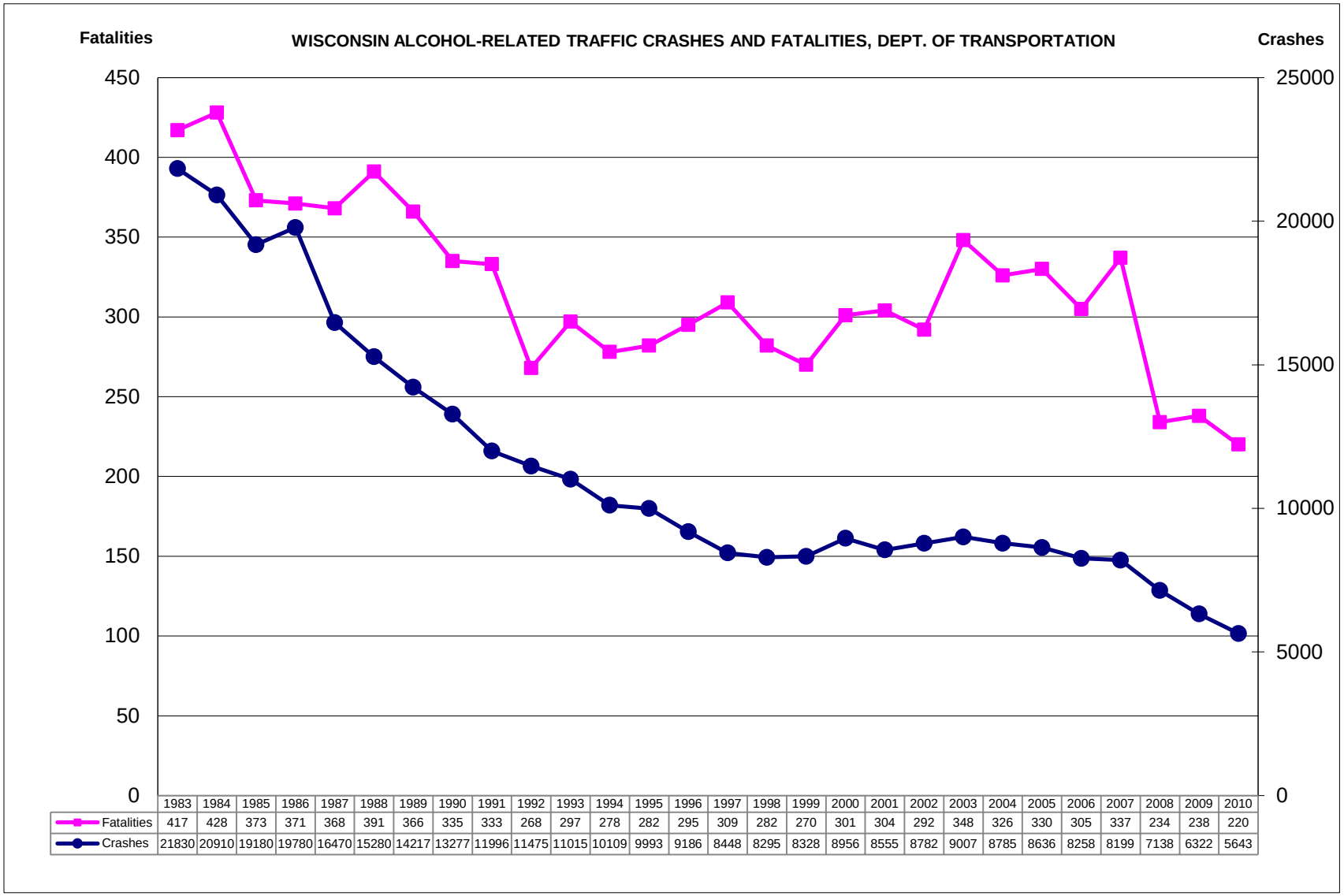
Some of the available substance abuse data indicators can be used to assess the overall performance of Wisconsin's substance abuse prevention and treatment system. Surveys indicate that adult substance use disorder prevalence may be declining recently, but the percent of Wisconsin residents having a substance use disorder is still above the national average and it is above the Wisconsin rate from 10 years ago. For youth, the rate of substance use disorders has been relatively flat for the past 10 years and it too is above the national average. Hazardous binge drinking is trending downward for adults and youth while marijuana use among youth in the past 15 years is up though the Wisconsin rate of marijuana use is below the national average. Tobacco use among youth is trending downward.

The average age of Wisconsin deaths due to excessive alcohol consumption is about 56 according to death certificate data.[92] Alcohol-related conditions cited on death certificates that can precipitate early death include alcohol dependency, alcohol abuse, alcoholic cardiomyopathy, alcoholic hypertension, cirrhosis of the liver, pancreatitis, a lethal blood alcohol level and suicide. Mood-altering drug deaths include deaths where the death certificate cites a controlled, habit-forming drug such as heroin, other prescription opiates, cocaine, methamphetamine, marijuana, hallucinogens or prescription tranquilizers, barbiturates or stimulants were an underlying cause of death. Drug deaths exclude overdoses related to aspirin, anti-depressants and other non-habit-forming medicines and substances. Obtained from the Wisconsin Office of Health Informatics, the figure below tracks Wisconsin alcohol and mood-altering drug deaths over the past 40 years. While there has been some leveling off of these deaths recently, the overall long-term trend is upward.



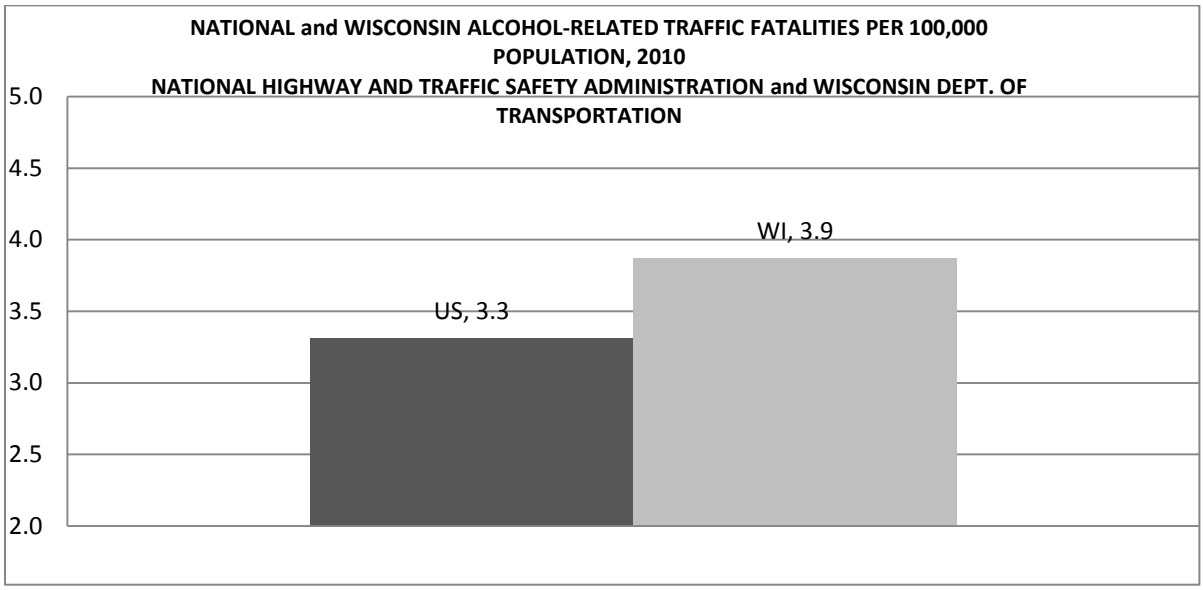
	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Drugs	95	109	98	100	97	83	118	87	83	94	117	83	56	65	89	75	88	85	106	92	83	125	107	147	209	216	197	225	290	293	363	375	464	496	547	658	725	790	728	775	767
Alcohol	231	249	257	262	296	330	331	318	322	328	394	398	279	305	294	344	300	305	298	337	303	415	395	623	672	687	667	659	735	763	839	830	850	874	869	964	970	1045	994	955	1033

Operating a motor vehicle under the influence of alcohol or other mood-altering drugs is a public safety issue causing injuries and deaths. The National Survey on Drug Use and Health (2004-2006) found that Wisconsin was the highest state in the country in self-reported driving under the influence with 26% of adult Wisconsin survey respondents reporting this behavior. The national average was 15%. The chart following presents over 25 years of Wisconsin traffic crash and fatality data from the Wisconsin Department of Transportation.[93] Since 2008, after years of slight increases, the annual number of crashes and fatalities is again trending downward.

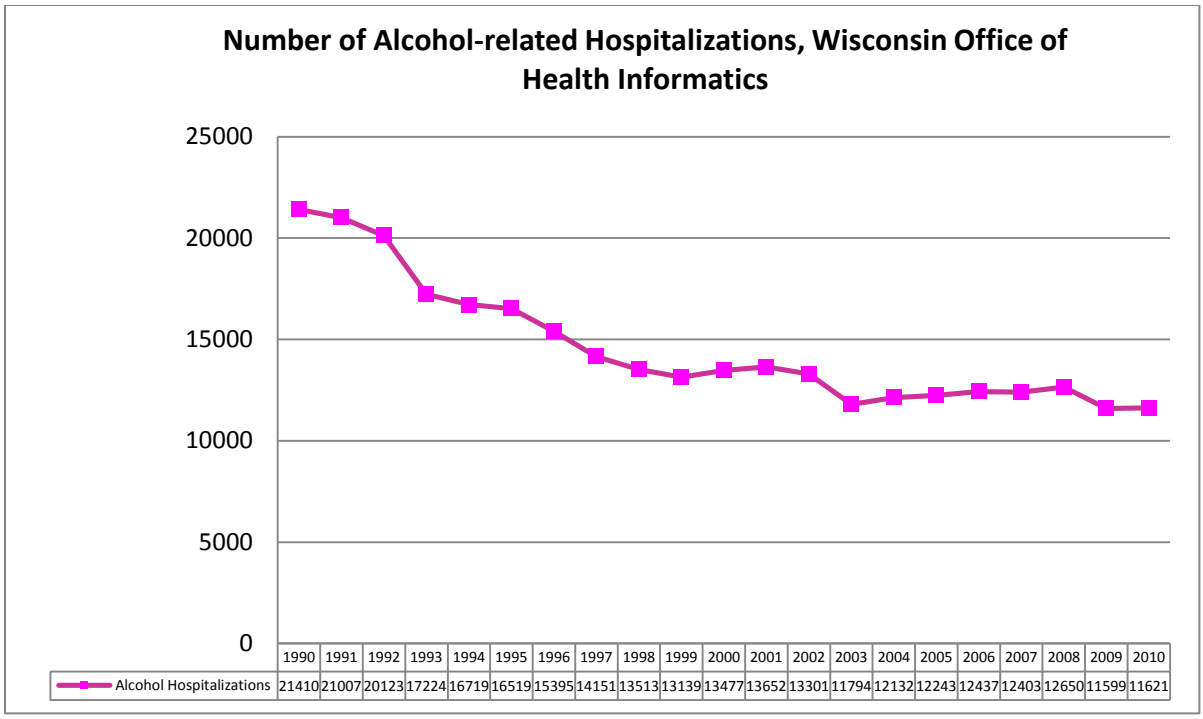


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Fatalities	417	428	373	371	368	391	366	335	333	268	297	278	282	295	309	282	270	301	304	292	348	326	330	305	337	234	238	220
Crashes	21830	20910	19180	19780	16470	15280	14217	13277	11996	11475	11015	10109	9993	9186	8448	8295	8328	8956	8555	8782	9007	8785	8636	8258	8199	7138	6322	5643

Wisconsin alcohol-related traffic deaths are higher than the national average. After converting the data to number of deaths instead of deaths per 100,000, the next chart on U.S. and Wisconsin alcohol-related traffic fatalities shows that Wisconsin has 32 more alcohol-related traffic crash fatalities each year than would have occurred if Wisconsin's rate were the same as the national rate.[94]



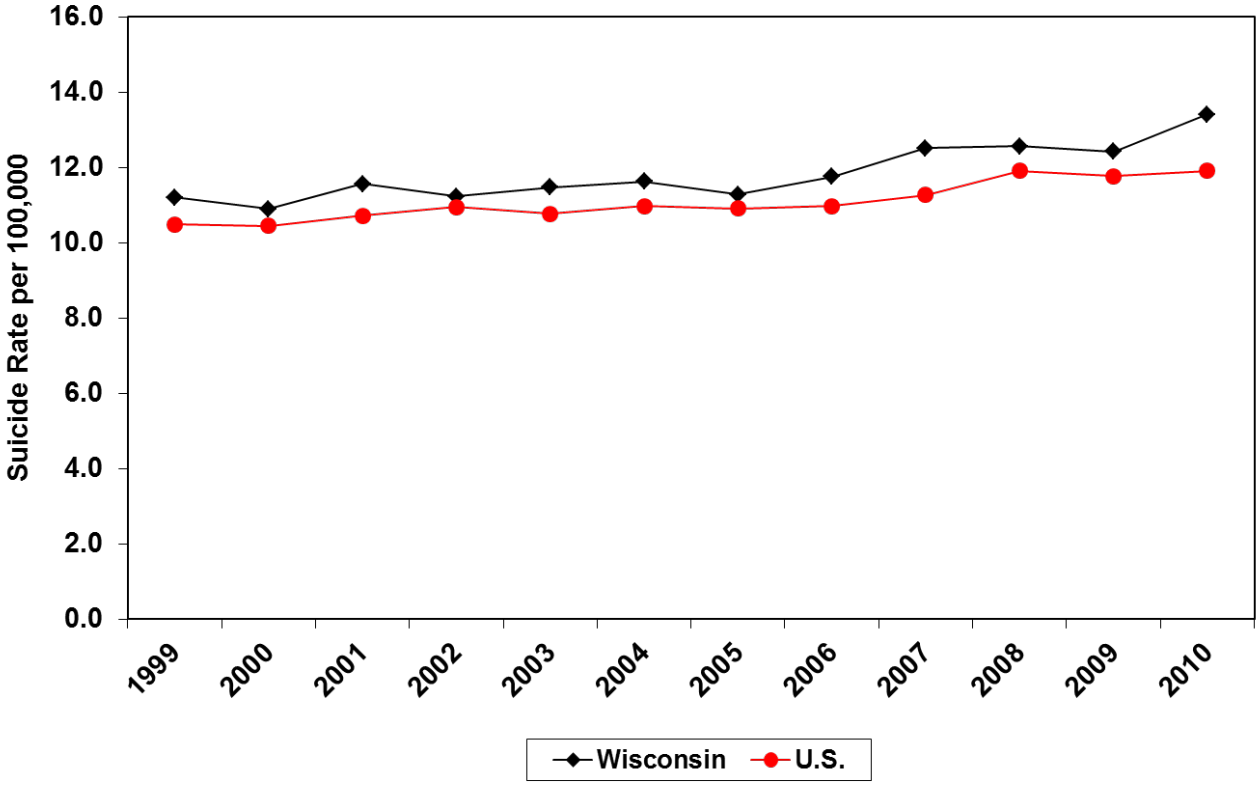
Like deaths, alcohol-related hospitalizations are also an important tracking indicator of the impact of the substance abuse services system on substance abuse and related illness and disease. The reported data for alcohol-related hospitalizations were obtained from hospital inpatient discharge data collected by the Wisconsin Hospital Association Information Center.[95] These hospitalizations include the same conditions as the death data (i.e., alcohol dependency, alcohol abuse, alcoholic cardiomyopathy, etc.) and do not include emergency department cases. Alcohol-related hospitalizations have leveled off in recent years after declines during the decade of the 1990s.



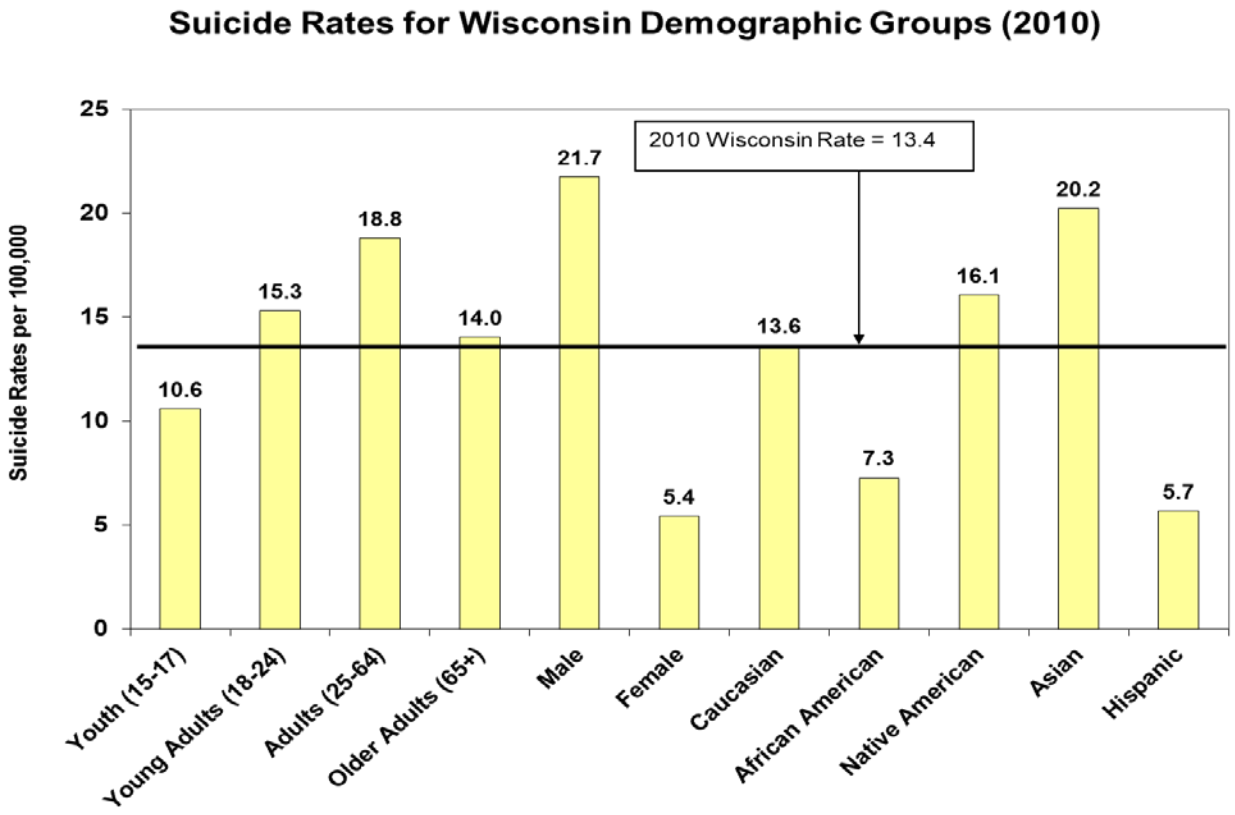
Mental Health

Of the impacts on the general population related to mental health disorders, one of the most severe impacts is through suicides. In 2010, the total number of suicides in Wisconsin was 791 which is a rate of 13.4 per 100,000 people[96]. The trend in suicide rates from 1999-2010 is displayed in the chart below and indicates a gradual rise in the rate since 2005. From 1999-2005, the suicide rate did not change much from 11.2 to 11.3 respectively. But from 2005-2010, the suicide rate increased by two points per 100,000 from 11.3 to 13.4 with a one point increase occurring in 2010 alone. The national rate[97-99] has consistently been below Wisconsin's by less than a point except for in 2010 when the gap widened to 1.5 due to the increase in Wisconsin's rate.

Wisconsin and U.S. Suicide Rates 1999-2010



The chart below demonstrates suicide rates for different demographic groups. From 2006-2010 in Wisconsin, 79% of suicides were committed by males. The highest suicide rate is for adults ages 25-64. However, the smaller group of adults deserving attention are 50-59 year olds. While suicide rates for many age groups have varied slightly over 2006-2010, the only rate that has steadily risen is for people ages 50-59. Further illustrating the high risk of suicide in this age group is the fact that 45-59 year olds commit the highest rate of suicides at about 22 per 100,000 in 2010. For racial and ethnic groups in Wisconsin, Caucasians commit 92% of suicides in Wisconsin which is disproportionately high relative to their 88% share of the population. The numbers of suicides in non-Caucasian groups is often too small to show reliable trends. However, the number of suicides for Asians should be monitored closely into the future because it tripled from 7 to 21 between 2009-2010.



While more recent data on suicide among veterans is not yet available, *The Burden of Suicide in Wisconsin* report showed that between the years of 2001 and 2006, veterans and/or active duty military service personnel accounted for about a fifth of all suicides[100]. As age increases, the proportion of suicides committed by veterans exponentially increases. In fact, amongst those ages 65-74, veterans made up about half of the suicide deaths between 2001 and 2006.

Economic Impact

Substance abuse in general causes an economic impact in Wisconsin that is both positive and negative. From a synthesis of 21 substance abuse treatment cost-benefit studies, when substance abuse is treated, each dollar spent on treatment results in a $6.35 return to Wisconsin in increased employment earnings, reduced health care costs, and reduced costs of crime.[101] From a synthesis of 14 substance abuse prevention cost-benefit studies, for each dollar invested in substance abuse prevention, an average benefit of $7.65 is realized in reduced health care and social services costs, reduced public assistance, reduced crime costs and increased potential earnings.[102] However, unaddressed substance abuse exacts an economic toll of over $3 billion on Wisconsin's $230 billion annual economy (U.S. Department of Commerce, Bureau of Economic Analysis) in terms of health care, crime, traffic crash, public assistance and lowered work productivity costs.[103]

According to the federal Centers for Disease Control, binge drinking accounts for more than 40,000 deaths each year across the country including homicide, impaired driving, suicide, heart

disease and liver failure, $167.6 billion in economic costs ($3 billion Wisconsin projection from personal income data), and 1.5 million years of potential life lost.[104, 105]

The estimated societal cost of opiate abuse in the United States is $25 billion in excess health care costs and an additional $31 billion in criminal justice, public assistance and lowered productivity costs ($1 billion Wisconsin projection).[106]

According to the National Highway and Traffic Safety Administration, the medical, legal, productivity, and property cost per traffic fatality is estimated at $1.1 million.[107] For the 220 Wisconsin alcohol-related traffic fatalities that occurred in 2010, the cost is over $240 million.

The annual cost to society associated with depression has been estimated at $30 billion to $44 billion in the U.S. annually ($800 million Wisconsin projection)[108]. Similarly, the total annual cost associated with schizophrenia in the United States has been estimated at $62.7 billion ($1 billion Wisconsin projection)[109]. These estimates include direct costs such as treatment and medication, criminal justice system costs, and capital costs for mental health facilities, along with indirect costs such as loss of productivity in the workplace for clients and their family members.

4. OTHER STAKEHOLDER INPUT ABOUT SERVICE NEEDS

Consumers and Consumer Advocates

Input from consumers and consumer advocates was obtained through a survey asking about the most important unmet needs, populations and service improvements that should be addressed. In addition, the United We Stand Wisconsin Network of the Grassroots Empowerment Project (a state-wide organization controlled and directed by mental health consumers/survivors whose purpose is to help people labeled with a mental illness exercise power in their lives) conducted a listening session among consumers/survivors. Their most important needs are as follows in no particular order:

- Healthcare
- Prevent mental health hospitalizations
- More consumer-run support groups or centers
- More Peer Specialists
- Prevent or provide mental health services for persons who come in contact with the criminal justice system
- Address stigma and discrimination
- Protect or increase public funding for mental health services
- Affordable public or private health insurance

Tribal Nations

Wisconsin's eleven Tribal Nations provided input through the above-mentioned survey as well as listening sessions conducted during 2012. Their most important needs are:

- Shortage of mental health and substance abuse professionals, in-home services and services in general
- Community awareness, education and prevention of mental health and substance use conditions
- Protect or increase public funding for mental health and substance abuse services; Medicaid reimbursement for case management and traditional tribal healing methods and other funding-related issues
- Training for mental health and substance abuse professionals
- Transitional housing
- Integrated services for co-occurring mental health and substance use disorders

Report-derived Problems, Issues, and Gaps Needs Prioritization Process

This needs assessment report presents a multitude of data-driven problems, issues, needs and gaps. Given current resources, we cannot realistically address all the needs and so the next step will be to identify those needs and gaps in the report that stakeholders feel have the greatest severity, fiscal impact, occurrence, solution know-how and resources.

A tool based on a public health program priority rating model[1] (Appendix A) was developed for stakeholders to more objectively rate and rank the needs identified through this needs assessment report. To be equitable to both the mental health and substance abuse fields and to both the prevention and treatment approaches, it was decided to group the needs or issues into three categories, namely 1) prevention and treatment needs common to mental health and substance abuse, 2) mental health prevention and treatment needs, and 3) substance abuse prevention and treatment needs. The table below presents the rated and ranked priorities from which we will develop objectives, strategies and performance indicators for the top-ranked needs to be included in the Block Grant application.

Score	Item	Item Description
81.2	SA-2	Reduce substance use disorders for pregnant women and mothers with infants and young children.
79.9	MHSA-3	Increase children and youth who receive effective treatment and wrap-around services for mental health or substance use disorders. Youth have high rates of mental health and substance abuse needs.
79.6	MH-1	Increase psychiatrist availability including, but not limited to, child psychiatrists in northern Wisconsin.
77.7	MHSA-4	Increase persons coming in contact with the criminal justice system that receive effective services for mental health or substance use disorders. These persons have high prevalence rates.
77.4	MH-2	Reduce Wisconsin's suicide rate below the national average including but not limited to persons age 50-59, veterans and active service members.
77.0	SA-8	Reduce alcohol and other substance-impaired motor vehicle crashes, injuries and fatalities among persons age 16-34.
75.8	MHSA-11	Improve mental health and substance abuse service outcomes and quality of care by addressing the use of evidence-based practices and treatments, practice-based evidence, consumer satisfaction and involvement, professional training, data collection, outcomes measurement, quality improvement approach, etc.
75.0	SA-1	Increase the substance abuse treatment professional workforce statewide.
74.4	MH-4	Early identification of those who have experienced adverse childhood experiences such as abuse, divorced parents, or living with persons who have a mental health or substance use disorder coupled with proven interventions to build resilience.
74.3	MHSA-6	Address barriers to accessing mental health or substance abuse treatment including cost, motivation, transportation/distance, living in rural areas, and stigma in order to increase the number of persons receiving treatment.
73.9	SA-7	Reduce binge or heavy-occasion use of alcohol among persons age 18-34.
73.9	SA-6	Reduce use of alcohol among persons age 12-20.

73.3	SA-3	Reduce persons with addictions to prescription pain killers and heroin as well as overdoses and deaths among persons age 12 and older.
72.1	MHSA-1	Increase persons with any co-occurring mental health or substance abuse disorder who receive effective integrated treatment.
72.0	MHSA-8	Increase overall mental health and substance abuse workforce capacity and reduce waiting lists.
71.2	MHSA-9	Achieve mental health and substance abuse service appropriateness and equity by ensuring the appropriate mix of inpatient, detox, residential, intensive outpatient, outpatient, psychosocial rehabilitation services, crisis intervention, recovery support services, peer specialists, recovery coaches, consumer-run centers, narcotic treatment, etc.
70.6	MHSA-12	Reduce the disparities in access to effective, culturally and linguistically competent mental health and substance abuse services among populations of differing races, ethnicities, sexual orientations and Deaf persons.
69.9	SA-5	Increase capacity to provide evidence-based, universal indirect environmental prevention strategies in areas of the state where data indicates there is need including but not limited to rural villages and towns.
69.8	MHSA-5	Increase young adults (age 18-25) and elders (age 60 and over) who receive effective treatment for mental health or substance use disorders. Young adult prevalence rates are higher than average and both groups' rates of receiving treatment are lower than average.
69.1	MH-3	Reduce mental health inpatient readmission rates by increasing the availability of community-based alternatives.
68.8	MHSA-2	Increase veterans, active service members and military families who receive effective treatment for mental health or substance use disorders.
67.1	SA-4	Reduce high usage of detoxification services in areas where usage exceeds the state or national average.
66.6	MHSA-10	Collaboration or integration of substance abuse and mental health services with primary health care to improve overall health outcomes including but not limited to smoking cessation.
63.0	MH-5	Provide parents and helping professionals working with infants and young children (e.g., child care workers, home visitors, and pediatricians) the knowledge, skills, and practices that support healthy social and emotional child development.
55.3	SA-9	Reduce the use of synthetic drugs that have a similar effect as marijuana (spice) or stimulants (bath salts).
51.9	MHSA-7	Address access barriers to pathological gambling disorder treatment in order to increase the number of persons receiving treatment.

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APPENDIX A

2012 Mental Health and Substance Abuse (Behavioral Health Assessment and Plan)
Needs Rating Sheet

Rate the need on each of the 8 criteria below using the rating scales provided. Just one number can be entered in the Rating column for each of the 8 criteria.

Need:
_____

Criteria	Rating
1. The physical and emotional health and functioning impact (illness, injury, disease, disability, death) on the individual, family or affected others. **Mild/low: 1 2 3 4 5 6 7 8** - Mild or no impact on overall emotional well-being or physical condition - Permanent disability unlikely with mild or no impact on ability to perform major social roles (e.g., work, school, parenting, family relationships) - Chronic medical condition or serious injury unlikely (low risk) - Need for medical, mental health or substance abuse services low (education; short-term ambulatory situational care or services) **Moderate/medium: 9 10 11 12 13 14 15 16** - Moderate impact on overall emotional well-being or physical condition - Permanent disability unlikely with moderate impact on ability to perform major social roles (e.g., work, school, parenting, family relationships) - Early or premature (before age 65) death unlikely (low risk) but chronic medical condition or serious injury likely (moderate risk) - Need for medical, mental health or substance abuse services moderate (long-term low intensity ambulatory and/or short-term 24-hour situational care or services) **Severe/high: 17 18 19 20 21 22 23 24** - Severe impact on overall emotional well-being or physical condition - Permanent disability very likely (high risk) with severe impact on ability to perform major social roles (e.g., work, school, parenting, family relationships) - Early or premature (before age 65) death likely (high risk) - Need for medical, mental health or substance abuse services high (long-term high intensity ambulatory and/or long-term 24-hour care or services)	_____ (1-24)
2. The negative financial or economic impact (e.g., cost of health/medical/mental health/substance abuse/social or other special services or care or treatment, criminal justice system or public assistance; cost to employers; or loss of income) on the individual, family or society or addressing the need successfully will result in a	

positive cost-benefit to society. **Mild/low: 1 2 3 4 5 6** - Low negative financial impact on the individual, family or society and low financial or economic costs or losses - Addressing the need successfully will result in a low positive financial impact on the individual or family and a low financial or economic benefit to society **Moderate/medium: 7 8 9 10 11 12 13** - Moderate negative financial impact on the individual, family or society and moderate financial or economic costs or losses - Addressing the need successfully will result in a moderate positive financial impact on the individual or family and a moderate financial or economic benefit to society **Severe/high: 14 15 16 17 18 19 20** - The financial burden on the individual, family or society is severe causing extreme financial hardship or economic costs or losses - Addressing the need successfully will result in a documented, very beneficial financial impact on the individual or family and high financial or economic benefit to society	_____ (1-20)
3. Know-how, evidence-based practice, a service, a program or a strategy and the resources to effectively address the need or there are service quality, outcome or consumer satisfaction issues. **Mild/low: 1 2 3 4 5** - Evidence-based practice or strategy not available and little know-how to effectively address the need - There is little consensus about the approach or strategy to address the need - The financial resources are not available to address the need - Service quality, outcome or consumer satisfaction is good **Moderate/medium: 6 7 8 9 10** - There is an evidence-based practice or strategy available or know-how to address the need - There is moderate agreement on the approach or strategy to address the need - The financial resources may become available to implement the approach or strategy to address the need - Service quality, outcome or consumer satisfaction problems are moderate **Severe/high: 11 12 13 14 15 16** - There is an evidence-based program, service or strategy in place to address the need - There is good consensus on the approach or strategy to address the need - The financial resources are sufficient to address the need - There are major service quality, outcome or consumer satisfaction problems	_____ (1-16)
4. Comparison to the national average or other accepted benchmark. **Mild/low: 1 2 3 4** - The need is consistently slightly (less than 5%) worse than the national average or other accepted benchmark **Moderate/medium: 5 6 7 8** - The need is consistently moderately (5% to 9%) worse than the national average or other accepted benchmark	_____ (1-12)

Severe/high: 9 10 11 12 - The need is consistently significantly (10% or more) worse than the national average or other accepted benchmark	
5. The size, magnitude, volume or occurrence of the need or there are significant service/strategy access issues such as availability, capacity or wait time. **Mild/low: 1 2 3** - Fewer than 5,000 persons are affected (less than 0.1% of the population) or - Access, availability or capacity issues or wait time are minimal or nonexistent **Moderate/medium: 4 5 6 7** - 5,000 to 99,999 persons are directly affected (0.1% to 1.9% of the population) or - Access, availability or capacity issues or wait time are moderate **Severe/high: 8 9 10** - 100,000 or more persons are directly affected (2% or more of the population) or - Access, availability or capacity issues or wait time are significant	_____ (1-10)
6. Consumers, consumer advocacy groups and other stakeholders have identified the need as a priority and/or will be involved in addressing the need. **Low: 1 2** - Consumers, consumer advocacy groups and other stakeholders have not identified the need as a priority or - Consumers, consumer advocacy groups and other stakeholders will not be directly involved in planning or implementation **Medium: 3 4 5** - Consumers, consumer advocacy groups and other stakeholders have identified the need as medium priority or - Consumers, consumer advocacy groups and other stakeholders will be somewhat involved in planning or implementation **High: 6 7 8** - Consumers, consumer advocacy groups and other stakeholders have identified the need as a high priority or - Consumers, consumer advocacy groups and other stakeholders will be directly involved in planning or implementation	_____ (1-8)
7. The need shows a negative trend over time. **Mild/low: 1 2** -The need shows a consistent positive trend over time.	

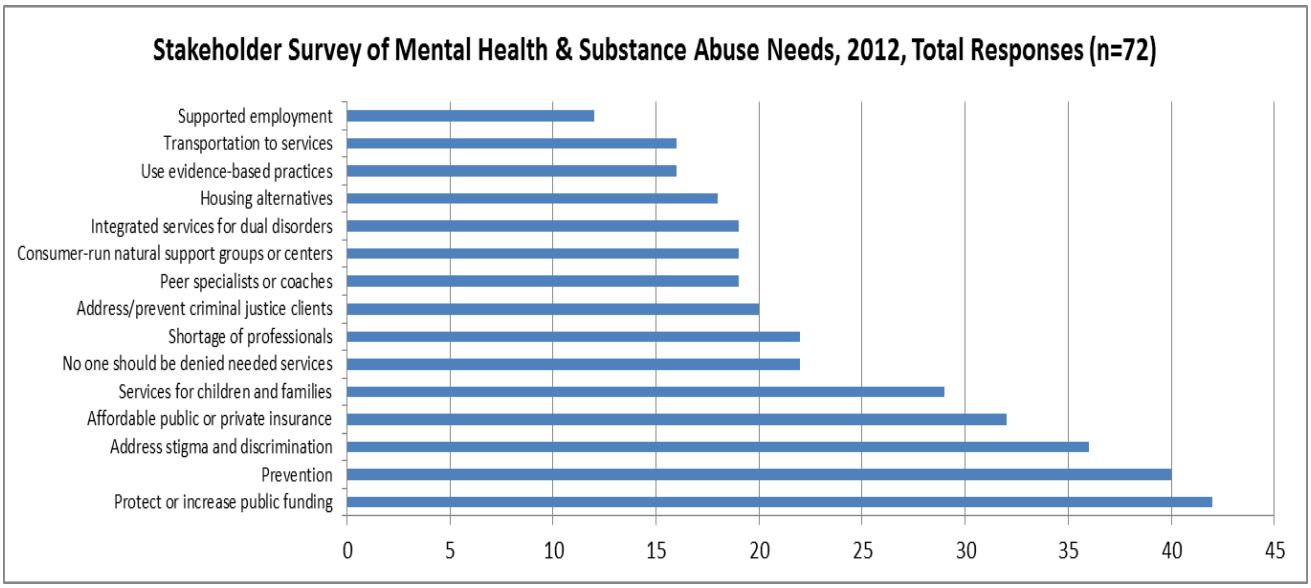
Moderate/medium: 3 4 -The need shows a consistent stable or inconsistent trend over time **Severe/high: 5 6** -The need shows a consistent negative trend over time	_____ (1-6)
8. Federal or state government has officially identified the need as a high priority. **Low: 1** - The Federal or State government has not officially identified the need as a priority or it is a low priority **Medium: 2** - The Federal or State government has officially identified the need as a medium priority **High: 3 4** - The Federal or State government has officially identified the need as a high priority	_____ (1-4)
TOTAL	

Comments:

APPENDIX B

Stakeholder Survey of Mental Health and Substance Abuse Needs, 2012

	Consumers or Consumer Advocates n=28	County Agency Staff n=20	Private Providers n=11	Tribal Agency Staff n=8	Veterans n=5	TOTAL
Protect or increase public funding	21	13	2	5	1	42
Prevention	11	16	8	3	2	40
Address stigma and discrimination	24	6	2	2	2	36
Affordable public or private insurance	15	8	7	0	2	32
Services for children and families	9	10	9	0	1	29
No one should be denied needed services	14	3	5	0	0	22
Shortage of professionals	12	2	5	2	1	22
Address/prevent criminal justice clients	14	4	2	0	0	20
Peer specialists or coaches	15	1	2	1	0	19
Consumer-run natural support groups or cente	7	6	4	1	1	19
Integrated services for dual disorders	4	5	7	3	0	19
Housing alternatives	10	5	2	0	1	18
Use evidence-based practices	8	1	6	1	0	16
Transportation to services	5	7	0	2	2	16
Supported employment	10	2	0	0	0	12
72 Responses from a total of 32 Counties						
The vast majority of respondents chose to comment on both mental health & substance abuse						
Bolded needs are also a priority of the United We Stand Wisconsin network of the Grassroots Empowerment Project; **health care** received (8) responses; **preventing hospitalizations** (7)						



APPENDIX C - MEASURING MENTAL HEALTH NEEDS

Wisconsin SMI Definition

Wisconsin has used the following definition to identify its adult population with serious and persistent mental illness. Wisconsin State Statutes define chronic serious and persistent mental illness in section 51.01(3g) as:

"Chronic serious and persistent mental illness" means a serious and persistent mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. "Chronic serious and persistent mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or of alcohol or drug dependence.

SAMHSA SMI Definition

Based on the recommendations of the federal Center for Mental Health Services (CMHS), Wisconsin calculates prevalence rates from a 1997 SAMHSA study entitled "A Methodology For Estimating The 12-Month Prevalence Of Serious Mental Illness (SMI)."[4] The definition of SMI used in the study to derive the prevalence rates includes:

1. 12-month prevalence of non-affective psychosis or mania,
2. 12-month DSM-IV mental disorder and either planned or attempted suicide at some time during an individual with a DSM-IV diagnosis over the last 12 months and lacks any productive role,
3. an individual with a DSM-IV over the last 12 months who has a serious role impairment in their main productive roles, and
4. An individual with a DSM-IV over the last 12 months with serious interpersonal impairment.

Appendix 2

Section C –Table

Coverage of Mental Health and Substance Use Disorder Services

Service	Covered by Medicaid*	Covered by QHP**
Healthcare Home/Physical Health		
General and specialized outpatient medical services	X	X
Acute Primary care	X	X
General Health Screens, Tests and Immunizations	X	X
Comprehensive Care Management - Targeted CM	X*	
Care coordination and Health Promotion	X*	
Comprehensive Transitional Care	X	X
Individual and Family Support		
Referral to Community Services Dissemination		
Engagement Services		
Assessment	X	X
Specialized Evaluations (Psychological and Neurological)	X	X
Service Planning (including crisis planning)	X	
Consumer/Family Education	X *	
Outreach		

Outpatient Services		
Individual evidenced based therapies	X	X
Group therapy	X	X
Family therapy	X	
Multi-family therapy		
Consultation to Caregivers		
Medication Services		
Medication management	X	X
Pharmacotherapy (including MAT)	X	
Laboratory services	X	X
Community Support (Rehabilitative)		
Parent/Caregiver Support		
Skill building (social, daily living, cognitive)	X*	
Case management	X*	
Behavior management	X*	
Supported employment	X*	
Permanent supported housing		
Recovery housing		
Therapeutic mentoring		
Traditional healing services		

Recovery Supports		
Peer Support	X*	
Recovery Support Coaching	X*	
Recovery Support Center Services		
Supports for Self Directed Care		
Other Supports (Habilitative)		
Personal Care	X	
Homemaker		
Respite	X***	
Supported Education		
Transportation	X	
Assisted living services	X*	
Recreational services		
Trained behavioral health interpreters		
Interactive communication technology devices		
Intensive Support Services		
Substance abuse intensive outpatient (IOP)	X	X
Partial hospital	X	X
Assertive Community Treatment	X*	
Intensive home based services	X*	

Multi-systemic therapy		
Intensive Case Management	X*	
Out-of-Home Residential Services		
Crisis residential/stabilization	X	
Clinically Managed 24 Hour Care (SA)	X*	X
Clinically Managed Medium Intensity Care (SA)	X	X
Adult Mental Health Residential	X*	
Youth Substance Abuse Residential Services	X*	
Children's Mental Health Residential Services	X*	
Therapeutic foster care		
Acute Intensive Services		
Mobile crisis services	X	
Peer based crisis services		
Urgent care services	X	X
23 hour crisis stabilization services	X*	X
Medically Monitored Intensive Inpatient (SA)	X*	X
24/7 crisis hotline services	X	X
Prevention (Including Promotion)		
Screening, Brief Intervention and Referral to Treatment	X	X
Brief Motivational Interviews	X	

Screening and Brief Intervention for Tobacco Cessation	X	X
Parent Training		
Facilitated Referrals		
Relapse Prevention/Wellness Recovery Support	X*	
Warm Line		
System improvement activities		
Other		

Footnotes:

* Some Medicaid funded benefits are available to individuals based on severity of need, for certain target populations or for individuals enrolled in specialized Medicaid benefit programs.

** Awaiting further information from DHHS on coverage of any additional Behavioral Health services.

*** Available in Children's SED Waiver

Appendix 3

Scott Walker
Governor

State of Wisconsin

Shel Gross
Chairperson

Judy Wilcox
Vice-Chairperson

Wisconsin Council on Mental Health
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

The Wisconsin Council on Mental Health (Council) is the statutory mental health planning council for the State of Wisconsin. In order to meet the Council's obligation to review and provide comment on the proposed Community Mental Health Services and Substance Abuse Treatment Plan for Wisconsin, two standing committees of the Council, the Adult Quality Committee and the Children and Youth Committee, met separately for early review and comment on the combined Mental Health Plan during March 2013. Council members who may not have been on either of these committees were invited to attend. Some input from the committees was incorporated into the draft Plan and reviewed by the Council at its meeting on March 20, 2013. The draft State Plan was distributed through networks and posted on the Council's website for public review twelve days before the Council meeting to allow ample time for Council members and members of the public to review the draft Plan.

The Council met for its review and made final recommendations with respect to the FFY 2014 Community Mental Health Block Grant (MHBG) application in compliance with section 1915(a)(2) of Public law 102-231. Members of the public were also invited to comment. The invitation to participate in the Public hearing portion of the State Plan review was extended broadly to counties, advocates, consumers, family members and others. Members of the Council and the public were also invited to provide comments to the State via email. At its meeting on March 20, 2013, Council members reviewed and considered comments made by committees, Council members, and individuals attending the public hearing and individuals submitting email testimony and considered the Department of Health Services' responses, in our decision to support submission of the Plan. The Council empowered the Executive Committee to consider any additional comments and finalize this transmittal letter at its meeting of April 26, 2013.

The Bureau of Prevention Treatment and Recovery (BPTR) within the Division of Mental Health and Substance Abuse Services (DMHSAS), is responsible for development of the State Plan and supporting the Council. The BPTR's new Mental Health Planner, Ryan Stachoviak, coordinated the BPTR's efforts to design and develop Wisconsin's FY 2014-2015 Block Grant Application.

A critical component of the development of the State Plan was development of the Wisconsin Mental Health and Substance Abuse Needs Assessment. In preparation for a combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application the Council executive committee met with the executive committee of the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA). At this meeting the two Councils decided to create a combined Ad Hoc Needs Assessment Committee consisting of members of the two Councils and their committees to oversee the needs assessment process in collaboration with the BPTR. The Ad Hoc Needs Assessment

Committee met nine times with BPTR staff and provided additional input into the process through emails and surveys.

This combined process enabled members of each Council to gain a better understanding of the needs and issues being addressed by the sister council. There was also strong agreement on the value of the needs assessment itself. It brought together various sources of information and served to educate members of the two councils about the sort of data available and the gaps in that data. This is important information for the Council as it moves ahead. The needs assessment played an important role in the process of prioritizing goals for the block grants. Both Councils appreciated the considerable work put into the needs assessment by many BPTR staff. The two Councils will continue to explore how best to coordinate their efforts and continue to work together in the future.

The following comments and discussion occurred among Council members:

- S. Gross asked why suicide was not included as a priority area, noting that Mental Health America does get money from the block grant for suicide prevention. J. Allen stated that the State was reluctant to include a suicide priority due to concerns of measuring the impact of the activities which are funded by the block grant for suicide prevention. Based on Council feedback the State decided to include Suicide Prevention as a priority area in the State Plan.

- R. Immler asked why priority number three, which is to increase psychiatrist availability, but not limited to, child psychiatrists, in northern Wisconsin, wasn't included as a priority in the Block Grant application. J. Allen stated that DHS has worked to identify the factors that go into the lack of psychiatrists. Again, the block grant alone can't necessarily solve this problem. Counties are allocated funding from the block grant which could be utilized by a county to address this need. As of now the state has not come to a solution on how to solve this psychiatrist shortage in Northern Wisconsin. Though through programs such as CCS and coordinated service teams an impact could be made. Again, this is one of the elements which would be hard to impact utilizing block grant funds.

- W. Benedict asked if the State is able to gather much data regarding how far the state has actually operationalized and institutionalized Evidence Based Practices (EBP) in the counties. Is this a priority for the grant application or for our own practices? J. Allen stated that the federal government does require the State to report on the number of EBPs. This number is difficult to measure as each person is treated by a practitioner who may not report to us directly, these numbers go through the counties. We have identified two programs areas, CSP and CCS to complete surveys which list EBPs utilized in those programs. They report how many people they served utilizing EBPs. That is the best method the State has identified thus far to measure that. But that does not include an inclusive list of all EBPs that may be utilized. W. Benedict questioned if in Wisconsin it is more a question of utilizing EBPs or a question of data reporting regarding the use of EBPs. T. Connor responded, stating counties in the state are doing more. DHS asks counties to report the number of people served. In outpatient DHS does not ask to report what type of treatments are used, such as Cognitive Behavioral Therapy. Statewide DHS focuses on CSP and CCS for reporting. J. Allen stated that the State does ask about fidelity to EBPs, and in the needs assessment it is reported that 61% say they utilize the ACT standard. W. Benedict asked if the state is making progress with the use of EBPs. T. Connor replied that there is much more that could be done, not only in how EBPs are used, but also in the data quality collected. The degree which EBPs are utilized in a way that is faithful to the model is not measured in detail. The State does rely on counties to explain how true to the model their programs are. J. Allen added that the state does have to look at the cost benefit of doing that sort of review.

- J. Wilcox asked if the peer run respite centers will need to be licensed. J. Allen stated that the state will be exploring what these centers will need to do in order to operate. S. Gross commented that peers don't think that this should be required, there will be appropriate stakeholders at the table for these decisions, but there are some concerns about this.

- S. Gross noted that on page 44 of the block grant, information regarding states monitoring the ACA is specifically requested. Should this be a priority, including information about how the state will do this? J. Allen stated that Wisconsin has not elected to set up exchanges this section is not as applicable. Additionally, the section in question is a requested section, not a required section. S. Gross stated that he believes that the BPTR and the WCMH have an obligation to monitor the ACA implementation as it has the potential to positively impact people with mental health treatment needs.

- J. Stephens commented that from criminal justice perspective it is important to involve consumers in these dialogues. She thinks the bureau has the best opportunity to model this practice with the Department of Corrections (DOC). DHS has given opportunities for peer involvement in the past. There are people in the criminal justice system who would benefit from having peer contacts while still incarcerated. This would allow them to live a better life, support recovery, and reduce recidivism. The DOC is making a lot of changes and this could be a good opportunity to involve peers into the process, and the BPTR can help by inviting consumers along.

- J. Wilcox commented that on page 83 the Wisconsin Real Choice Systems change grant portion should be removed because it no longer exists. As is the Section 811 program information.

- K. Eithun-Harshner commented that the WCMH Children and Youth Committee reviewed the block grant at their previous meeting. One comment which was raised was that there is a need to improve data collection pertaining to children's mental health. In addition the committee thought that because of the change in format there is less information regarding youth in the block grant overall.

The following public commentary was provided:

- Kuou Vang introduced himself to the Council. Mr. Vang, Board Secretary, represents the Wisconsin United Coalition of Mutual Assistance Associations, Inc. (WUCMAA). Mr. Vang provided members of the Council with a letter from the WUCMAA asking the Council to support and encourage Governor Walker to allocate funding to the WUCMAA for mental health prevention and intervention referral services to the Hmong/Asian population in Wisconsin (Attachment 1).

  Mr. Vang stated they have not been able to assist the Hmong population with mental health problems. They have written a letter to Governor Walker asking for his support. Mental health is a stigma in the Hmong culture; people don't like to talk about it because of cultural barriers. The WUCMAA would like to work around these cultural barriers, and allow for the discussion of the many components which impact mental health. Many Hmong have committed murders or committed suicide. These events could be prevented if we can understand mental health. The WUCMAA wants to remove the stigma from the Hmong community. Their goal is to make it ok to talk about and understand mental illness, for people to know that their problems are not spiritual control, but that it is something that people can receive help for.

  Mr. Vang told a story of a young Hmong man who needed services, but there are no Hmong services available. The WUCMAA frequently refer people to Journey Mental Health. Mr. Vang stated he would like Council support for these concerns. We want a healthy community, especially with mental health. Many people don't know how to seek help when they have a mental health need.

They are trying to provide support, helping the Hmong refugees, and would like the Council to support the efforts of the WUCMAA in their efforts to work with the Governor and the Secretary.

J. Stephens stated that she thinks an important factor in the Hmong community is trauma, and there could be a lot of work done around trauma informed care in this community with an understanding that trauma that can impact people and groups. S. Gross commented that Mai Zong Vue of DHS worked for the Department of Workforce Development on a Hmong refugee project and worked on mental health capacity in those communities. R. Immler recommended an example of St. Paul Ramsey in Minnesota which served the Hmong populations. St. Paul Ramsey could be used as a model of how to implement Mental Health Care for Hmong populations in Wisconsin. K. Vang stated that the WUCMAA met with the Secretary yesterday and they would like any information regarding services.

- Sandra Ahrens introduced herself via the conference phone and read a statement (Attachment 2).

- F. Boersma commented that she has been doing some traveling around the state and did receive some feedback that relates to the Block Grant. In regards to consumer satisfaction a better quality of life assessment was important to people. Of the four SAMHSA identified domains, purpose and community were very important to people. These two are regarded as being primary factors that got them into treatment and kept them well. Purpose and community are very important to consumers. J. Wilcox thought it would be a great idea for that organization to tackle creating a meaningful survey for themselves, one that could be tested for its validity, and test those types of quality of life measures. S. Gross commented that current documents utilized elsewhere may be valuable examples. J. Allen noted the Recovery Oriented Systems Indicators (ROSI) survey was previously used. The Mental Health Statistics Improvement Program (MHSIP) is the currently mandated tool for consumer input.

  M. Strittmater stated that La Crosse County utilizes the ROSI in the CCS program. He hopes the County will not have to utilize a new one. The nice thing about the ROSI was the ability to measure and compare across counties and systems. Many counties do not use the survey; however some Wisconsin counties still use the ROSI in addition to La Crosse.

- *G*regory Smith, Exec Director Cornucopia, Inc. provided a written comments via email (Attachment 3).

Wisconsin United Coalition of Mutual Assistance Associations, Inc.

419 Sand Lake Road, Onalaska, WI 54650 Phone: (608)781-4487 Web: www.wucmaa.org

Hmong American Association of Portage County
Stevens Point

Hmong American Community Association
Menomonie

Hmong American Friendship Association
Milwaukee

Hmong American Partnership
Appleton

United Hmong & Asian American Community Center
Green Bay

Hmong Community Center
Manitowoc

Lao Family Community
Milwaukee

Hmong Services Center
Oshkosh

Hmong MAA of Sheboygan
Sheboygan

United Asian Services of WI
Madison

Wausau Area Hmong MAA
Wausau

Shee Yee Community of
Milwaukee

3/20/2013

Shel Gross, Chairman and Members of the Mental Health Council
Wisconsin Council on Mental Health
1 W. Wilson, Room 951
PO Box 7851
Madison, WI 53707-7851

Dear Mr. Gross and Council Members:

I am representing the Wisconsin United Coalition of Mutual Assistance Associations, Inc. (WUCMAA) to ask your support our effort to address Hmong and Asian mental health. He are working with Governor Walker and Secretary Kitty Rhoades requesting funding for mental health.

A recent report released by the Asian American Justice Center(AAJC) last September 2012 reveals the 4 major causes of leading death among our 49,000 Hmong here in Wisconsin are: heart disease, cancer, accident, and suicide respectively - this is a disturbing trend.

We are pleased to see Governor Walker's announcement of an additional $30 million for mental health services. We want to bring to your (Wisconsin Council on Mental Health) attention the need to ensure our underserved Hmong population is being addressed by these funds. Hmong mental health issues are not adequately being addressed at the present time and we want you to ensure the Hmong are not being left out.

Despite the Hmong's resettlement in Wisconsin since 1976, many citizens of Wisconsin still do not know who the Hmong people are. Many Hmong children also do not know their history well today and suffer identity crisis that lead to delinquency. The Hmong are the people who worked with the United States Central Intelligent Agency (CIA) during the Vietnam War from 1960-1975 in Laos and here is how one U.S. Senator put it, "When our pilots were downed by anti-aircraft fire behind enemy lines in the Vietnam War, the CIA asked our Hmong allies to risk their lives to advance our cause," said Senator Murkowski of Alaska.

The Wisconsin Hmong and other Asians are also making great contribution to the Wisconsin economy. AAJC's report shows over 6,800 Asian businesses and employ nearly 16,000 Americans that generate about $470 million dollars in

payroll annually.

The Mutual Assistance Associations (MAA) in Wisconsin were founded since 1980 by the various refugee ethnic communities to serve them in rebuilding their new life here in Wisconsin. The MAAs were heavily engaged in the employment and training, immigration and naturalization services, language services, case management, business development and so forth.... Among the noticeable successes was the reduction of Hmong refugee cash assistance dependency. Hmong cash welfare assistance dependency was about 95% in 1980 and today with W-2 dependency is about 2% statewide. The MAAs now are moving from the traditional services to more advanced services such as cancer prevention, domestic abuse and violence prevention and intervention, health and mental health education, economic development and so on. Many MAAs still provide refugee services as well as community services to non-refugees. The MAA's have the local infrastructure and support system that continues to deliver social, health, and economic services to the Hmong and other Asians here in Wisconsin.

The Wisconsin United Coalition of Mutual Assistance Associations, Inc. (WUCMAA) was founded by the original ten MAAs across Wisconsin in 1986 to provide technical training, coordinate statewide planning, business development, and advocacy for the MAAs. Currently WUCMAA is actively working with 12 MAAs in 10 communities: Madison, Milwaukee, Sheboygan, Manitowoc, Green Bay, Appleton, Oshkosh, Wausau, Stevens Point, and Menomonie.

WUCMAA is a partner in the Wisconsin Tobacco Prevention and Control Program. We are pleased with the partnership in providing tobacco use prevention education to our Hmong and other Asians in Wisconsin since the tobacco lawsuit settlement funds became available for tobacco programs. WUCMAA also received fund from the Wisconsin Department of Commerce for its micro loan programs.

I am asking you (Wisconsin Council on Mental Health) to support and encourage Governor Walker to allocate $900,000 state General Purpose Revenue to WUCMAA for mental health prevention and intervention referral services to the Hmong/Asians here in Wisconsin. WUCMAA will be working with its MAA member agencies to deliver mental health prevention service and intervention referral through its cultural appropriate system and communication channels.

The MAAs have a good track record of refugee services and are in need of state financial resources to address the current mental health needs as indicated. Attached are letters we sent to Governor Walker and Secretary Kitty Rhoades. We are asking your support of this mental health initiative. Thanks you.

Sincerely yours,

Koua Vang, WUCMAA Board Secretary

Attachment 2

My name is Sandra Ahrens and I am commenting on behalf of Grassroots Empowerment Project, a statewide consumer-run organization with the mission to create opportunity for people with mental illness to exercise power in their lives. My experience has been in providing technical assistance and training to peer-run recovery centers across the state, and in providing peer specialist and other recovery trainings. Here are my comments:

Consumer-Driven Recovery is a concept, ideal and value that has developed into a range of evidence – based practices and should be at the center of any planning involving mental health. While the plan includes mention of consumer-run centers, peer specialists, and now includes peer-run respites, the amount of funding for peer-run and peer-provider services shows that consumer-driven recovery is not a priority and not integrated into the vision that drives the planning.

Meaningful Consumer Involvement needs to be a priority in developing the plan for use of community mental health block grant funds. Secretary Smith endorsed United We Stand Wisconsin's Consensus statement on Meaningful Involvement. However, simply including the priorities identified by consumers across the state in an appendix at the back of the needs assessment does not represent meaningful consumer involvement. I read in the report that altogether, the public and stakeholder input amounted to 72 respondents, which included, in addition, to consumers, advocacy groups, service providers, tribal agencies, Veterans and county intermediary agencies. I would like to suggest that the number of consumers involved, the selection process and level of involvement be detailed in future. Gaining and sustaining meaningful consumer involvement takes time, money and sustained effort, but it is essential to establishing priorities and quality services.

The use of peer specialists, peer-run recovery centers and peer-run respites are all evidence based, and all highly valued by people receiving mental health services. Two out of these 3 are established and we welcome the addition of the third. However, to be effective, they all need adequate funding, support, monitoring and evaluation. This is not currently the case with the first two, and to add a third initiative and not properly support will lead to the same outcome. To distribute insufficient funds among 3 types of peer services is to doom all three.

Attachment 3

Public Comment to Wisconsin Council on Mental Health
on the Wisconsin application for Community Mental Health Services
& Substance Abuse Prevention and Treatment Block Grant

2013 March 20
Gregory Smith, Exec Director
Cornucopia, Inc.

These are my own opinions, informed by fifteen years' involvement with Wisconsin peer-run centers, vocational programs, and certification courses for peer specialists. Currently i am part-time executive director of Cornucopia Inc, the peer-run arts and wellness center in Madison that is funded in part by the current Block Grant. I am also one of our center's representatives to the new Coalition Of Peer Empowerment, which aims to unify and strengthen peer-run services in Wisconsin.

The recovery and drop-in centers are a type of place that is scarce in most of our towns and cities. True accessible common spaces are no longer common in our communities. Many of our neighbors can seldom afford the price of a beverage that would allow them to sit and socialize at a popular mainstream establishment. Social phobias or discrimination create further barriers to inclusion and participation.

The small number of peer-run recovery and drop-in centers around Wisconsin are varied in style and sophistication. Walking into most of these places one can see they need better facilities and more staff. Still they are friendly and hospitable, people there are compassionate and accepting, and anyone seeking a peer connection can afford to visit and spend some time.

Within clinical practice a medication might rapidly control thoughts and feelings that impair function and growth. In contrast (or complement), peer support in an accepting social space can gradually inspire hope. For fifteen years we have had a small investment in the existing peer centers. This has increased our local capacity to invest in a chance for better life for each member who returns to our centers week after week, emerging from isolation to create a more satisfying life.

A review of peer services from 1989 to 2009 by the Center for Psychiatric Rehabilitation found that people who participate regularly in group peer services benefited in many ways. The twelve Wisconsin centers surveyed by Grassroots Empowerment in recent years have shown increases in socialization and personal resources.

In the statewide Needs Assessment, "service appropriateness" ranks high and includes recovery support and consumer-run centers. Other identified needs are access to treatment, reducing waiting lists, and increasing community-based alternatives. I would consider all these to have some relation to social peer supports.

Comment on application for CMHS & SAPT Block Grant
2013 March 20 Gregory Smith, Madison
(continued)

When I read the needs that were identified by consumer survey, I wonder if the survey asked "what helped you?" and if that would add any weight to peer relationships and social opportunities. In this draft application, the section on the strengths of our system in Wisconsin mentions every component except peer run centers.

Employing peer specialists is recommended to increase service capacity. For five years Wisconsin has invested in certified peer specialists (with no increase in the small allocation for group peer programs). The establishment of peer specialists as one-to-one advocates and mentors is important. They appear to improve engagement and recovery outcomes. A key factor in their success may be to establish a way to employ them independent of institutions, counties or hospitals, to minimize the conflict between interests of their employers and interests of the peers with whom they partner.

Fourteen rural counties are described as having greatest need for any mental health professionals. Nearly all counties have psychiatrist shortages. The community support programs have waiting lists. I think the total need in these regions would be helped in part through more widespread and well-supported peer-run centers.

Among the data that federal SAMHSA will be using with states in this block grant, is the community outcome of improving supportive relationships. The narrative plan in this application states that the Bureau funds and promotes evidence based peer support practices, and that standards will be developed for recovery centers over two years. These commitments represent investments of funds that require substantial attention to quality with time and energy from everyone.

Most of our service and correctional systems comprise highly developed personnel and technology requiring intensive resources. The distinction and beauty of most peer support, when done well, are in the time taken to establish individual relationships, and their lasting effects on personal growth and community. We need a much larger investment of funds and quality factors in this slower side of our recovery based system.