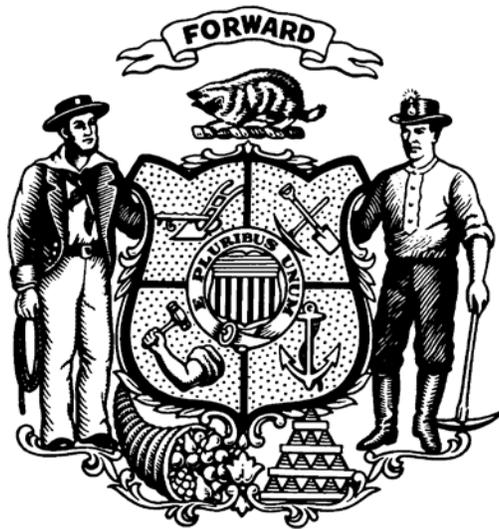


WISCONSIN STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE



June 5, 2015
MEETING

Michael Waupoose
Chairperson

SCOTT WALKER
Governor

State Council on Alcohol and Other Drug Abuse (SCAODA)

Strategic Plan July 2014 – June 2018

SCAODA GOALS:

1. Provide leadership and direction on AODA issues in Wisconsin by serving as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on AODA issues and promote collaboration across multiple sectors to advance progress on SCAODA goals.
2. Change Wisconsin's cultural norms to transform the state's AODA problems into healthy behavioral outcomes.
3. Inform Wisconsin citizens on the negative fiscal, individual, and societal impacts of substance abuse.
4. Advocate for adequate funding, capacity, and infrastructure to implement effective outreach, prevention, treatment, and recovery services for all in need.
5. Remedy historical, racial /ethnic, gender, and other bias in substance use disorder systems, policies, and practices.

SCAODA PRIORITIES for 2014-15

1. Expand substance use disorder workforce capacity
2. Address population-specific needs
3. Reduce harmful alcohol consumption
4. Inform the public about substance use disorder-related consequences
5. Increase the use of evidence-based practices in prevention, treatment, and recovery
6. Address emerging substance use disorder trends

This page has been intentionally left blank and does not contain any information.



Tobacco-Free Environment

American Family Insurance is a tobacco-free environment. We prohibit the use of tobacco products everywhere, by anyone, at all times.

- Use of tobacco products is prohibited in all interior and exterior spaces, including inside your vehicle while on company-property and in parking ramps and parking lots.
- We ask that you refrain from using tobacco products while using our facility.

Thank you for your cooperation. We welcome you and look forward to serving you!

Meeting Coordinator – Please make sure the meeting participants are aware American Family is a Tobacco-Free Environment.

This page has been intentionally left blank and does not contain any information.



SCAODA 2015 Meeting Dates

**American Family Insurance Conference Center
6000 American Parkway
Madison, WI 53783**

All meetings will be from 9:30am to 3:30pm and will be in Building C, Room CL3300 A&B

The meeting dates are:

March 6, 2015

June 5, 2015

September 11, 2015

December 11, 2015

This page has been intentionally left blank and does not contain any information.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

June 5, 2015

MEETING AGENDA

9:30 a.m.

American Family Insurance Conference Center
6000 American Parkway, Madison, WI 53783

Building C, Room CL3300 A&B

American Family General Information: (608) 242-4100 ext. 31555 or ext. 30300

Please call Kris Moelter at (608) 267-7704 or email kristina.moelter@wisconsin.gov if you or your designee will not attend the meeting.

- 9:30 a.m. I. Introductions / Welcome / Pledge of Allegiance / Announcement Noise Level / Agenda – Michael Waupoose
- 9:35 a.m. II. Review/Approval of March 6, 2015 minutes – Michael Waupoose....pp. 16
- 9:40 a.m. III. Public input (maximum five minutes per person) – Michael Waupoose
- 9:45 a.m. IV. Committee reports

SCAODA goals				
Provide Leadership	Change the Culture	Educate Citizens	Sustain Infrastructure	Address Disparities

- Executive Committee – Michael Waupoose....pp. 21-24
 - Bill McCulley
 - SCAODA budget recommendations....pp. 21-22
 - Recommendation on powdered alcohol legislation...pp. 23
 - SCAODA position on Pre-trial Intoxicated Driver Program
 - Nominating committee appointments
- Diversity Committee – Tina Virgil....pp. 25-35
 - Letter to SCAODA....pp. 25-27
- Intervention and Treatment Committee – Norm Briggs and Roger Frings....pp. 36-50
 - Substance abuse workforce ad hoc committee
 - Medication-assisted treatment
- Planning and Funding Committee – Joyce O'Donnell pp. 51-56
 - AODA funding update
 - MOTION: Screening and drug testing for applicants for the public benefit programs listed in the governor's proposed budget should be implemented as a pilot program in a limited number of counties and in such a way that evaluates quality of life outcomes for participants, such as

employability and control of the use of substances for individuals in various programs. Individuals who test positive must be further evaluated and have ready access to services to improve employability and control of the use of substances....pp. 51

- Prevention Committee – Scott Stokes....pp. 57-62
 - Marijuana ad hoc committee

- 10:45 a.m. V. • Biennial budget discussion/legislation update – DHS staff
- 11:00 a.m. VI. • Substance Abuse Block Grant application/needs assessment – Mike Quirke....pp. 63-123
- 12:00 p.m. VII. • LUNCH
- 12:30 p.m. VIII. • Trauma-informed care presentation – Scott Webb
- 1:30 p.m. IX. • Wisconsin Council on Mental Health Criminal Justice Committee update – Norman Briggs
- 1:35 p.m. X. • Secretary’s Council and Child Welfare update – Norman Briggs
- 1:45 p.m. XI. • State agency reports
 - Department of Revenue – Matthew Sweeney
 - Department of Health Services – Tom Engels
 - UW Systems – Anne Hoffmann
 - WTC – Katie Roberts
- 2:30 p.m. XII. • Agenda items for next meeting
- 2:35 p.m. XIII. • Announcements – Joyce Allen and Lou Oppor
- 2:45 p.m. IV. Adjourn – Michael Waupoose

<p style="text-align: center;">2015 Meeting Dates March 6, 2015 June 5, 2015 September 11, 2015 December 11, 2015</p>

Presentations from the State Council on Alcohol and Other Drug Abuse meetings are recorded and can be found online at: <http://scaoda.state.wi.us/presentations.htm> .



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE
MEETING MINUTES

December 12, 2014

9:30 a.m.

American Family Insurance Conference Center
6000 American Parkway, Madison, WI

Members present: Norman Briggs, Craig Harper, Kevin Moore, Joyce O'Donnell, Mary Rasmussen, Sue Shemanski, Duncan Shrout, Scott Stokes, Michael Waupoose

Members absent: Bud Coxhead, Douglas Englebert, Cheryl Eplett, Steve Fernan, Roger Frings, Sandy Hardie, Charlotte Rasmussen, Tina Virgil

Ex-officio members present: Randall Glysch, Tom Heffron, Anne Hoffman, Katie Paff, Katie Roberts, Matthew Sweeney

Ex-officio members absent: Kathy Marschman, Linda Preysz

Staff: Joyce Allen, Ashleah Bennett, Lee Ann Cooper, Pat Cork, Sarah Coyle, Tanya Hiser, Andrea Jacobson, Bernestine Jeffers, Paul Krupski, Cody Michels, Kris Moelter, Lucas Moore, Christy Niemuth, Lou Oppor, Mai Zong Vue

Guests: Richard Bryant, Denise Johnson, Tera Cater Vorpahl, Sue Gudenkauf, Dave MacMaster, Lori Pesch, Sheila Simonson

Michael Waupoose called the meeting to order at 9:35 a.m.

I. Introductions – Meeting attendees introduced themselves.

II. Approval of September 12, 2014 minutes – Kevin Moore moved (Duncan Shrout second) to approve the September 12, 2014 meeting minutes. The motion passed unanimously.

III. Public input – None.

IV. Committee reports

- **Executive Committee** – Mr. Waupoose introduced Katie Roberts, a representative from the Wisconsin Technical College System.

He reported that the Executive Committee has met two times since the September SCAODA meeting. The first meeting was to review the proposed Department of Safety and Professional Services' rule relating to substance use disorder professionals that would allow them to receive credit for online education courses. The Executive Committee sent a letter in support of the proposed rule. The second meeting was to review a proposed rule to change the educational and other requirements for professional counselors, marriage and family therapists, and licensed social workers to receive a substance abuse specialty. The Executive Committee opposes the proposed rule as drafted and recommends it be changed to maintain the requirements for psychopharmacology, the ICRC examination, and the supervisor certification as exists in the current rule. Mr. Waupoose will attend the public hearing on December 19 and provide testimony on behalf of SCAODA.

Mr. Waupoose reviewed the legislator education material that was distributed. Joyce O'Donnell reported that the Planning and Funding Committee put together the material and will work with the Executive Committee to distribute the materials to the legislators once the committee assignments are made for the next session.

He also reported on the Legislative Council study committee on treatment courts and diversion for which he serves as the SCAODA representative. The committee will recommend three legislative actions for the next session. The first is to provide funding to continue to provide grants for local criminal justice coordinating councils, treatment courts, and treatment alternatives and diversion programs. The second is to create family and juvenile drug treatment courts within the Department of Children and Families. The third is to allow courts to have access to ignition interlock device reports and to shorten the waiting time to receive a driver's license if the person is participating in a diversion program.

- **Diversity Committee** – Mai Zong Vue, staff person for the Diversity Committee, reported the committee is reviewing data and conducting a needs assessment for underserved populations. It will receive regular data reports from DHS to help with the assessment. The committee also is revisiting the CLAS standards and working on developing a definition for diversity. SCAODA members had a discussion on the future of the Diversity Committee. That committee will discuss how it sees its role within SCAODA and report back at the March meeting.
- **Intervention and Treatment Committee** – Norman Briggs reported the substance abuse workforce committee is close to completing its work. Mr. ShROUT said the committee has developed a series of recommendations that it will bring the SCAODA in 2015.

Mr. Briggs reported that the ITC is focusing on methadone clinics to ensure they are providing the best possible service to its clients. He also reported that the committee has not yet received a response from DHS or DCF on SCAODA's request that it form a workgroup to look at screening for parents with children in the child welfare system. Mr. Waupoose asked the committee to also look at how suboxone and vivitrol are prescribed in the state.

- **Planning and Funding Committee** – Ms. O'Donnell reported that the committee held a public forum at the annual mental health/substance abuse conference. The main issue that was discussed was the substance use disorder workforce. She reported that the committee will form an ad hoc committee to review and make recommendations on how substance use is funded in Wisconsin. Todd Campbell will chair that committee. She said the committee will work with legislators to change the SCAODA statute to increase the SCAODA membership from 22 to 27 per a prior SCAODA motion. The committee's recommendation is that the additional members be treatment providers, one from each of the DHS administrative regions.
- **Prevention Committee** – Scott Stokes reported that the committee is working on a system to follow up on reports and status of recommendations that are made in those reports. The committee currently has an ad hoc committee looking at marijuana. It has formed workgroups to address prevention, legalization and regulation, medical marijuana, and treatment/recovery.

The committee held two public forums at the Alliance for Wisconsin Youth training. The committee is reviewing the comments and report back at a later meeting. It is working on a statewide prevention conference to be held in 2015, as well as two substance abuse prevention specialist trainings for 2015.

V. Wisconsin Council on Mental Health update – Mr. Briggs is the SCAODA liaison with the council. He reported that the Department of Corrections may expand the OARS (Opening Avenues to Re-Entry Success) program. That program helps inmates with mental illness re-integrate into the community. The Department also now provides inmates with a month's supply of medications when they leave the institutions.

VI. Bylaws amendments – Mary Rasmussen reviewed the proposed bylaws amendments. The amendments were:

- To consolidate some of the listed SCAODA duties listed in Article I, Section 3—(d) and (k) would be combined and (i) and (j) would be combined
- Article II, Section 2.4 (c), limiting ex-officio members to four-year terms, would be eliminated
- Article II, Section 2.9 (c) would be amended to add that SCAODA vacancies would be publicized to stakeholders of all ethnic groups
- Article II, Section 3.4, relating to the past chairperson, would be eliminated and the reference to the past chairperson in Article IV, Section 5 would also be eliminated
- Article III, Section 6 would be amended to make the meeting attendance requirements applicable to committees and would eliminate 6.4 and 6.5

- Article IV, Section 1.2 would eliminate the requirement that the Diversity Committee have a standing subcommittee on the Americans with Disabilities Act

Mary Rasmussen moved (Mr. Shroul second) to approve bylaws. The motion passed unanimously.

VII. Epidemiological Report presentation – Christy Niemuth gave a presentation on the 2014 Epidemiological Report that was recently published by DHS. The priorities that will be addressed based on the data are (1) underage drinking (2) adult binge drinking (3) drinking among pregnant women (4) drinking and driving.

VIII. Synar Report – Nancy Michaud presented the annual Synar Report. The report details compliance with the laws related to sales of cigarettes to minors. The retailer violation rate must be below 20 percent. If it is not the state could lose up to 40 percent of its Substance Abuse Block Grant funds. This year’s rate is 6.4 percent, compared to 7.3 percent last year. Wisconsin’s rate has consistently stayed below the national average of 10 percent, usually at about five percent. Before Wisconsin had year-round compliance checks, the violation rate exceeded 20 percent. While use of cigarettes is down among youth, the use of smokeless tobacco, e-cigarettes, and other tobacco products is increasing. A copy of the report is included in the meeting materials.

IX. State agency reports

- **Department of Revenue** – Matthew Sweeney reported that the excise tax collections overall are down 1.64 percent over last year through October 2014. Cigarette taxes are down 2.35 percent while other tobacco taxes are up just over 2 percent. Liquor tax collections are up 2.2 percent and beer tax collections down 1.5 percent.
- **Department of Health Services** – Mr. Moore reported that DHS is asking for over \$2 billion over the next two years to fund the Medicaid program. There are 1.18 million Wisconsin residents on Medicaid. There are over 136,000 childless adults, which is more than the budget estimate of 98,000. That is still within the budget.

He reported that the department has a new website and that DMHSAS Administrator Linda Harris is retiring.

- **UW Systems** – Anne Hoffmann reported that there is an upcoming assessment to survey students and their substance use. The survey has substance use, mental health, physical health, and sexual health questions. In prevention initiatives they are doing marijuana prevention and have captured social norms data and are sharing that data with students. UW System is working on engaging parents in prevention.
- **Wisconsin Technical College System** – Ms. Roberts reported that the technical college system is in the process of systematizing its curriculum so that all course learning outcomes will be clear and the same. Each faculty member will still have the freedom to interpret the curriculum, but the learning outcomes must be met. She also reported

that the number of people taking the technical college responsible beverage services classes has declined as more private vendors offer the course for less money. A member of the legislature is concerned that the private curriculum is not as rigorous so he will look at possible legislative changes to strengthen the curriculum and delivery for responsible beverage service.

X. Agenda items for the March 6, 2015 meeting

- Workforce development ad hoc committee report
- Budget/legislation update
- Presentation on medication-centered therapy

XI. Announcements – Lou Oppor reported that DHS will release a request for proposal for the opiate treatment program by the end of the year. Up to three centers will be funded. The programs will be designed so they could expand to address other emerging drug use in the future.

Kris Moelter reported that the annual Substance Abuse Block Grant report was submitted to SAMHSA. Wisconsin met most of the goals and the goals that were not completely met were partially met and will be met within the next year.

Joyce Allen reported the legislative assembly has created a mental health reform standing committee although no committee appointments have been made.

XII. Adjourn –The meeting adjourned at 12:31 p.m.

2015 SCAODA meeting dates:

March 6, 2015
June 5, 2015
September 11, 2015
December 11, 2015



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851

Madison, Wisconsin 53707-7851

STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE
MEETING MINUTES

March 6, 2015

9:30 a.m.

American Family Insurance Conference Center
6000 American Parkway, Madison, WI

Members present: Norman Briggs, Douglas Englebert, Tom Engels, Steven Fernan, Roger Frings, Sandy Hardie, Craig Harper, Joe Hoey, Devin LeMahieu, Joyce O'Donnell, Charlotte Rasmussen, Mary Rasmussen, Sue Shemanski, Duncan Shrout, Scott Stokes, Tina Virgil, Michael Waupoose

Members absent: Bud Coxhead

Ex-officio members present: Randall Glysch, Anne Hoffman, Kathy Marschman, Katie Paff, Katie Roberts

Ex-officio members absent: Jamie Elder, Michelle O'Shasky, Linda Preysz, Matthew Sweeney

Staff: Joyce Allen, Ashleah Bennett, Pat Cork, Tanya Hiser, Andrea Jacobson, Bernestine Jeffers, Paul Krupski, Cody Michels, Kris Moelter, Lucas Moore, Christy Niemuth, Lou Oppor, Mai Zong Vue, Raina Zwadzich

Guests: Richard Bryant, Todd Campbell, Denise Johnson, Luke Petrovich, Tera Cater Vorpahl, Dave MacMaster, Michelle Wick

Michael Waupoose called the meeting to order at 9:33 a.m.

I. Introductions – Meeting attendees introduced themselves.

II. Approval of December 12, 2014 minutes – Duncan Shrout moved (Joyce O'Donnell second) to approve the December 12, 2014 meeting minutes. The motion passed unanimously.

III. Public input – None.

IV. Committee reports

- **Executive Committee** – Mr. Waupoose introduced the new SCAODA members. Devin LeMahieu is the Republican Senate representative and Janet Bewley is the Democratic Senate representative. Her staff person, Joe Hoey, attended today’s meeting. Tom Engels is the new DHS Deputy Director and is the new DHS representative to SCAODA.

Mr. Waupoose reported that he received a joint letter from the Department of Health Services and the Department of Children and Families in response to SCAODA’s request that the two departments form a committee to address the substance use disorder needs of parents with children in the child welfare system. The departments issued an invitation for SCAODA to appoint a representative to the DCF Secretary’s Council on Child Welfare. Norman Briggs is the SCAODA representative on that council.

The SCAODA education packets have been distributed to the members of the legislature.

The Executive Committee met on February 20 to review pending legislation and budget items. The committee decided to oppose a bill that would allow for distilled liquor samples to be given at liquor stores and grocery store liquor departments. The committee hearing on the bill was scheduled for February 25, thus necessitating the Executive Committee action.

Mr. Waupoose reported that the Department of Safety and Professional Services’ proposed rule change that would allow substance use disorder counselors to meet some educational requirements online has been sent to the legislature for approval. SCAODA supported that change.

He also reported that he testified on behalf of SCAODA on a proposed change to the DSPS rules on social worker and other counselor educational requirements. SCAODA supported some of those changes but opposed others. Katie Paff said the rule as drafted has been sent to the legislature and governor. The legislature will refer the proposed rule to a committee where it will be considered and there will be an opportunity for comment.

Mr. Waupoose reported that the Legislative Council Problem-Solving Courts Committee on which he represented SCAODA has submitted proposals for legislation.

Mr. Waupoose is also working on a National Governor’s Association initiative on the healthcare workforce. He will keep that committee informed on SCAODA’s progress on addressing the substance use disorder counselor workforce.

- **Diversity Committee** – Tina Virgil reported that the committee is gathering information and data on diverse populations in certain geographical areas to determine the need for substance use disorder treatment and the services available. The committee is also researching whether the CLAS standards are being implemented in the geographic areas on which the committee is focusing. The committee will teach a breakout session at the

annual mental health/substance use conference in the fall of 2015. The committee is developing a website and logo and will give a presentation to SCAODA in September.

- **Intervention and Treatment Committee** – Mr. Briggs reported that the committee has had a change in membership and is looking for more treatment providers. He also reported on the status of the Substance Use Disorder Workforce ad hoc Committee. The committee has finished meeting and is drafting the report. ITC expects to present the report to SCAODA at the September meeting. The Children and Families Subcommittee has begun meeting again. ITC is also looking at medication-assisted treatment and is using the SCAODA Heroin Report to inform it on the treatment aspect.
- **Planning and Funding Committee** – Ms. O’Donnell reported that the committee discussed the budget issues at its February meeting. An ad hoc committee is looking at how AODA services are funded in Wisconsin and what needs there are for AODA services.
- **Prevention Committee** – Lou Oppor reported that the Marijuana ad hoc Committee has been meeting and expects to present its report to SCAODA in December. The committee has four workgroups--treatment/recovery; legality/regulation; medicinal; and prevention. He also reported that there will be a statewide prevention training institute on June 11-12 and the committee will host a public forum during the institute.

V. Biennial budget discussion/legislative update – Kris Moelter presented information about the proposed biennial budget. The Planning and Funding Committee and the Diversity Committee recommended SCAODA support the provision expanding Medicaid reimbursement for the treatment portion of residential substance use disorder treatment and oppose the drug testing provisions of the bill or make suggestions on how to change the drug testing provisions in the proposed bill.

MOTION: Ms. O’Donnell moved (Mr. Briggs second) to support expanding Medicaid reimbursement to cover the treatment portion of residential substance use disorder treatment. The motion passed 12 yes, 0 no, and 5 abstentions (Tom Engels, Tina Virgil, Devin LeMahieu, Roger Frings, Charlotte Rasmussen).

MOTION: Ms. O’Donnell moved (Mr. Shrouf second) to oppose the drug testing provisions of the proposed budget.

This motion generated much discussion, most of it centered around the portion of the recommendations from the Planning and Funding and Diversity Committees on how the bill should be changed if the legislature wants to pass a drug testing bill. Council members were concerned about the recommendation that all recipients of public benefits be drug tested. That could mean most people in the state would need to be drug tested. The proposals lack detailed information at this point. Ms. Moelter said there may be more information contained in the Legislative Fiscal Bureau budget papers when those are released. **Ms. O’Donnell withdrew the motion and the Planning and Funding, Diversity, and Intervention and Treatment**

Committees were directed to review the drug testing proposals at their April meetings and make recommendations so the Executive Committee can take action at its April 17 meeting.

Ms. O'Donnell expressed concern that the Safe Ride Program continued to be funded. Mr. Briggs asked about the Department of Corrections' proposed pilot program to provide Vivitrol to inmates. Ms. Moelter said the only details publicly available now are contained in the chart that was sent to the SCAODA distribution list earlier in the week. Mr. Waupoose asked DHS staff to try to get more information and the Executive Committee would address this item at its April 17 meeting.

VI. Medication-assisted therapy presentation – Tanya Hiser presented on medication-assisted therapy. The powerpoint is attached as part of the meeting minutes.

VII. Wisconsin Council on Mental Health Criminal Justice Committee update – Mr. Briggs reported that the Department of Corrections has taken significant steps to ensure people with substance use disorders can apply for Medicaid prior to release from the institution. In past inmates could not apply for benefits until after release from the institution.

VII. State agency reports

- **Department of Health Services** – Pat Cork reported on the peer run respite initiative. All three centers are open—one in Madison, one in Appleton, and one in Menomonie. The capacity varies among centers, but all have between three and five beds. Joyce Allen reported that the coordinated services team initiative continues to expand. All tribes and all but five counties offer this approach. The other initiative DHS has started is comprehensive community services. This initiative is for people needing a higher level of support. A person in the CCS program is assessed and then an individualized treatment plan is developed. She also reported that DHS is working with the Department of Veterans Affairs on an outreach and recovery program. The program is designed to identify veterans with mental health and/or substance use disorder concerns who are homeless or are at risk of being homeless. Mr. Oppor reported that a Request for Proposal for three opiate treatment centers has been released. The centers will be in rural areas that are underserved and where there is high need. DHS hopes the programs will be operating by July 2015.
- **Department of Justice** – Ms. Virgil reported that DOJ is continuing its heroin initiative efforts. She also reported that the Drug Enforcement Agency is no longer leading drug take back efforts. DOJ has agreed to take on a leadership role so the program will continue. DOJ also will continue its cannabis eradication and suppression program. The program is funded with federal money and supports local agencies to conduct marijuana investigations.
- **UW Systems** – Anne Hoffmann reported that UW Systems has invited 50,000 students to participate in a substance use survey. They hope to have the results in six to eight weeks. UW-Stevens Point is hosting a “marijuana 101” summit for university personnel that will provide current research and best practice information in a time of changing

perceptions and policies about marijuana. UW is continuing to work on instructions regarding the proposed budget cuts. At this time it is unclear how the proposed cuts would affect AODA personnel.

- **Department of Public Instruction** – Steven Fernan reported that the Youth Risk Behavior Survey will be administered in the spring of 2015. The survey is completed every two years. There are core questions that the federal government requires be asked and the state can add other questions. The survey will not ask about heroin use in 2015 but will in 2017. DPI recently has been awarded several federal grants that are being implemented this school year. He also reported that there is a bill in Congress that contains a provision that would restore formula grant funding that would allow school districts to address AODA and violence prevention. Much of that funding ended when Congress stopped funding the Safe and Drug Free Schools formula grant about five years ago.

X. Agenda items for the June 5, 2015 meeting

- Budget/legislation update
- Needs assessment and draft Substance Abuse Block Grant application

XI. Announcements – Ms. Moelter reported that the federal Substance Abuse Block Grant application is due on September 1, 2015. One of the requirements is for states to conduct a needs assessment. DHS will update the needs assessment that was completed two years ago and that assessment will be presented to SCAODA at the June meeting for review and input into setting the application's priorities. The formal public hearing on the application will be held at the July Wisconsin Council on Mental Health meeting.

XII. Adjourn –The meeting adjourned at 1:25 p.m.

2015 SCAODA meeting dates:

~~March 6, 2015~~

June 5, 2015

September 11, 2015

December 11, 2015

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Mary Rasmussen
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

March 31, 2015

Governor Scott Walker
115 East
State Capitol
Madison, WI 53702

RE: Proposed budget

Dear Governor Walker:

I am the chairperson of the State Council on Alcohol and Other Drug Abuse (SCAODA), a statutory council charged with advising the Governor and Legislature on matters related to alcohol and drug use. Wis. Stat. §14.24(4) requires SCAODA to review the biennial state budget bill and make recommendations to the Governor and Legislature regarding the plans, budgets, and operations of all state alcohol and drug abuse programs.

The SCAODA Executive Committee has reviewed the proposed budget and considered input from the full council and its other committees. Based on that input, the Executive Committee:

- **Supports the expansion of Medicaid to cover the treatment portion of residential substance use disorder treatment** – Medicaid reimbursement for substance use disorders is inadequate to cover provider costs. While that problem is not addressed in the proposed budget, expanding Medicaid for residential treatment is a much-needed improvement to the current Medicaid reimbursement structure.
- **Opposes the drug testing proposals** – The proposed budget contains provisions to drug test recipients of some public benefits. The Executive Committee opposes all of those proposals as they are currently written. SCAODA supports the early identification of substance use disorders and providing effective treatment. This bill does not do that. While the committee recognizes there may be a place for workplace drug testing, the budget as drafted falls short in that it does not contain adequate funding for substance use disorder treatment, singles out only some public benefit recipients, and does not use evidence-based practices to identify and treat substance use disorders.

Governor Scott Walker
Page 2
March 31, 2015

SCAODA appreciates the opportunity to comment on the proposed budget. Thank you for your time, and please do not hesitate to request our assistance in the future.

Please contact me if you have any questions at (608) 287-5701.

Respectfully,

A handwritten signature in cursive script that reads "Michael Waupoose".

Michael Waupoose, Chairperson

c: Tom Engels, DHS Deputy Secretary

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Mary Rasmussen
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

March 31, 2015

Senator Tim Carpenter
Room 109 South
State Capitol
Madison, WI 53707

RE: SB 10/AB 72 – powdered alcohol

Dear Senator Carpenter:

I am the chairperson of the State Council on Alcohol and Other Drug Abuse (SCAODA), a statutory council charged with advising the Governor and Legislature on matters related to alcohol and drug use. Part of SCAODA's statutory charge is to comment on pending legislation related to alcohol and drug issues.

SCAODA's Executive Committee has reviewed SB 10/AB 72 that prohibit the sale of powdered alcohol, and we voted unanimously to support these bills. We appreciate your efforts to protect the health, social, and economic well-being of Wisconsin's citizens. Please let me know if SCAODA can provide further support of your efforts.

Please contact me if you have any questions at (608) 287-5701.

Respectfully,

A handwritten signature in cursive script that reads "Michael Waupoose".

Michael Waupoose, Chairperson

c: Tom Engels, DHS Deputy Secretary

EXECUTIVE COMMITTEE MEETING MINUTES
March 31, 2015

Members present: Mary Rasmussen, Duncan Shroul, Michael Waupoose

Staff present: Kris Moelter

Michael Waupoose called the meeting to order at 9 a.m.

The committee discussed the proposed budget and reviewed the comments from the committees. Duncan Shroul moved (Mary Rasmussen second) to adopt the Planning and Funding Committee recommendation to oppose the drug testing proposals as written in the proposed budget. The motion passed unanimously.

Joyce O'Donnell, chair of the Planning and Funding Committee, asked the Executive Committee to support the SB10/AB72, the bills prohibiting the sale of powdered alcohol. Ms. Rasmussen moved (Mr. Shroul second) to send a letter to the bills' sponsors supporting the bill and asking them to reach out to SCAODA if SCAODA can provide further support. The motion passed unanimously.

Meeting adjourned at 9:25 a.m.

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Scott Stokes
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

February 25, 2015

Mr. Michael Waupoose
Chairperson of SCAODA
1 W. Wilson Street
P.O. Box 7851
Madison, WI 53707-7851

Dear Mr. Waupoose,

The purpose of this letter is to request the support of the Council to address concerns about barriers that appear to prevent the Diversity Committee and the Council from meeting their respective related missions, goals, and objectives identified in the attached chart.

The Diversity Committee is concerned about the following trends that are affecting development and deployment of a diverse workforce needed to be effective with underserved populations and bridge the gap created by unmet service needs.

- *Reports indicate that there is either current or a predicted shortage of counselors in the field. However, DSPS recognizes nearly 50 education and training programs for counselor preparation. Common anecdotal reports are that graduates of those programs are having difficulty gaining licensure and/or employment. These two items (predicted shortage and unemployed graduates) appear to contradict one another.*
- *Often discussed is a standard of requiring a bachelor's or master's degree for AODA counselors. This has never been required, and counselors with lower levels of education have been widely recognized as effective professionals for more than 30 years. Associate degree graduates (who receive far more education and training than the minimum required by rule) are prepared to work as counselors, but may have difficulty finding jobs if employers believe a higher degree is needed. This will increase the gap between workforce needs and eligible workers, especially those who can only afford or access a two-year degree.*
- *The degree discussion may be related to reimbursement issues. Higher degree requirements will increase costs for treatment and prevention services, essentially making access even more difficult for underserved populations. In general, state*

Medicaid reimbursement rates for recognized providers set the baseline for other insurance or managed care reimbursement decisions. The WI state Medicaid committee should be encouraged to recognize and define reimbursement rates for substance abuse counselors at all levels of licensure.

- *There seems to be some disconnection between preparation and access to practice in the field. At DSPS, where counselor credentialing occurs, there has been regular staff turnover in the area of counselor license application reviews. As a result, rules and expectations for counselor licensure applications have been interpreted differently by new staff than they were in the past, so many applications (including renewals) have been delayed or declined. Educators, trainers, and practitioners have no input into the process, leading to even more disconnection between training for employment, licensure preparation, and practice in providing on-going services.*
- *The end result is that underserved populations find it even more difficult to access well-trained, culturally competent service providers and members of under-represented population groups find the route to training and employment filled with higher costs and demands than they can bear. In addition, new professionals entering the workforce and those attempting to increase their licensure level find it frustrating to navigate the slow and ever-changing process.*

Therefore, the Diversity Committee respectfully requests that SCAODA take an active role in influencing the systemic issues that seem to create the barriers identified above. The Committee respectfully requests that SCAODA:

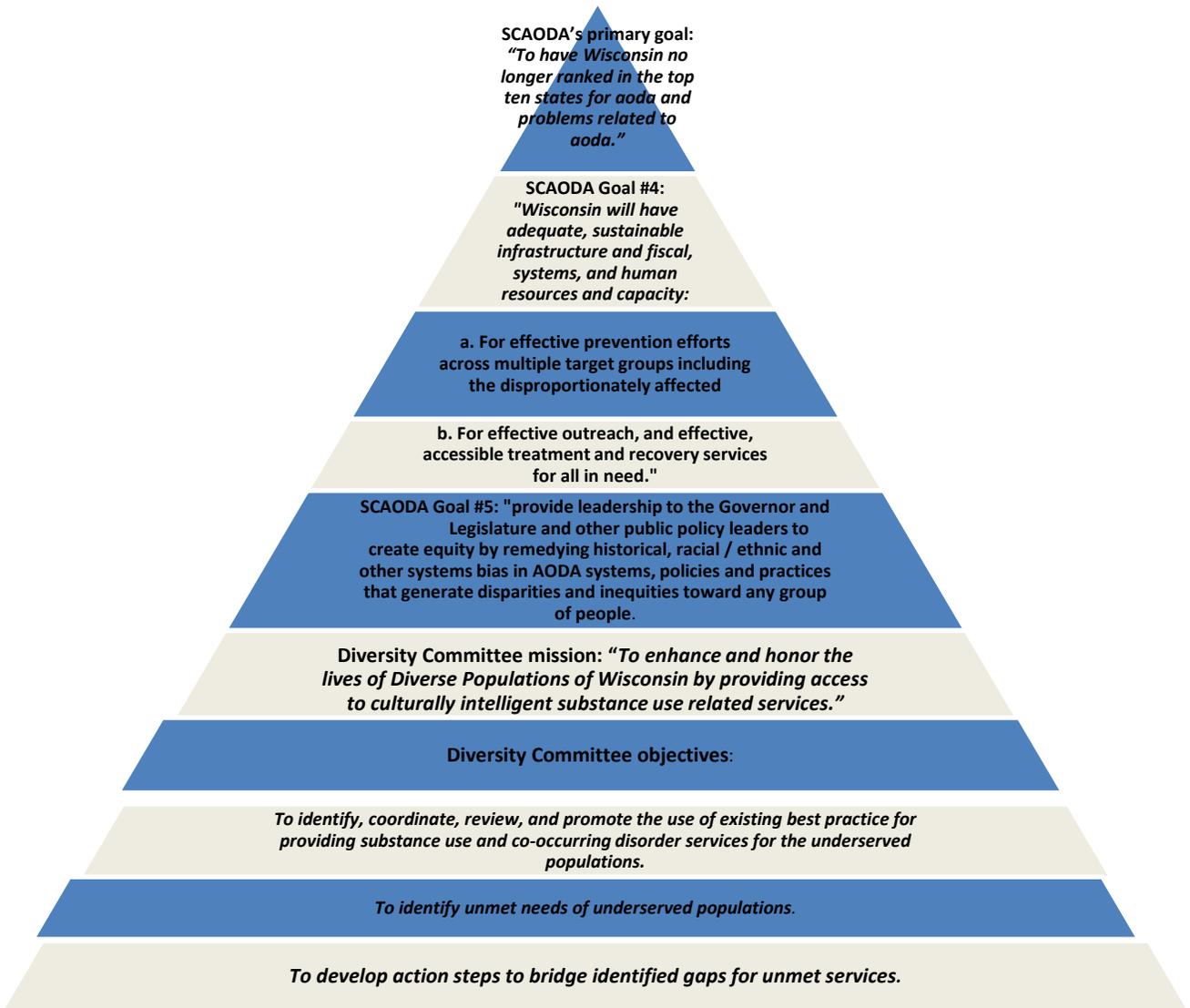
1) Communicate clearly and directly with the Department of Safety and Professional Services, the need to have an active, profession-representative board (including trainers and educators) to address rule changes and developments in licensure application processes for substance abuse counselors. (Note: In September of 2014, a small, 5-person, Substance Abuse Counselor Certification Review Committee was established for the primary goal of passing a rule change initiated by one of the committee members. They have had no other active involvement in the licensure rules or process for the profession. In addition, they are not widely representative of those in the profession.)

2) Initiate a liaison to work with the state Medicaid board to address underlying reimbursement issues that plague professional recognition and the subsequent devaluing of educated, trained, and licensed substance abuse counselors at all levels (SAC-IT, SAC, and CSAC).

Thank you for your support and consideration! Please don't hesitate to contact me with any questions. We look forward to your support in addressing these trends and unmet needs.
Sincerely,

Tina Virgil
Chair, Diversity Committee

Attachment
CC: Committee Members





State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

DIVERSITY COMMITTEE MEETING
February 20, 2015; 9:30 a.m. – 2:30 p.m.
DOJ Office, 2445 Darwin Road, Suite 200
Madison, WI

Meeting Minutes

Present: Tina Virgil, Cathy Scheier, Thai Vue, Denise Johnson, & Sandy Hardie

By phone: Gail Kinney

Staff: Mai Zong Vue; Kris Moelter

Guests: interpreters and Evelyn Cruz

Meeting Called to Order: Tina called the **meeting to order at 9:38 a.m.**

Public comment – none

Tina gave a brief orientation about the DOJ office to everyone!

Minute minutes: The January 23 meeting minutes was approved with a few amended changes.

Governor’s Budget:

Kris handed out a budget chart of AODA related budget items from the Governor’s budget to everyone. Kris walked through the chart and shared that the Planning and Funding Committee will support other expansion but opposed the drug testing of certain low income recipients because low income get tested but corporate CEO, students, and home owners do not get tested. Many questions were asked, including “Why was the bill created in the first place? There were no factual reasons available. Kris shared that according to available data in other states, there is no evidence showing that low income people use more drug than regular people. Florida’s program proved unconstitutional.

How do members share budget comments with the Council? Give to Kris or send written statements to Kris, or SCAODA members can give supplemental comments at the Council meeting. Below are some budget comments shared and discussed:

“The overall concern I have is that Wisconsin is demonstrating that mental health, AODA, and educational services do not address the gaps already out there. We can’t continue to find the same problem every ten-year cycle.” --Thai.

“We need to look at the whole system and the long term issues and help those that needed help.”– Cathy

“The irritation is that we will have relapsed people in the system and services. The system does not look at how people are recovered, but it is punitive how the law is written. We need to look at the issue, not just black and white.” –Sandy

“The system needs to focus on accountability, not penalizing people. It is not focusing on underserved population.” –Denise

CLAS Standard Follow-up with Evelyn Cruz:

Evelyn shared that the Public Health Plan 2020 identified disparities for underserved populations. In addition, she gave an overview of the challenges and progresses made from her office in implementing the CLAS Standards. Questions and comments discussed include:

1. How does this committee support the identified disparities within the Plan?
2. What is the Division and Bureau’s message to county providers regarding cultural competency issues?
3. There is limited data on the underserved issues and resources to do the work.
4. The Committee may need to ask the Council to recommend CLAS standard policy for program implementation for underserved populations.
5. The Diversity voice is important for underserved populations. The Diversity Committee needs a training matrix so members can do informal and formal education regarding diversity issues.
6. Evelyn will send CLAS Standard tools to Mai Zong to distribute to everyone!

Letter to Joint Board:

The letter drafted by Gail was reviewed and approved as submitted. A motion to approve the letter was made by Sandy and seconded by Denise.

Diversity Definition:

After much discussion about the reason for creating a definition—inclusive and consistency—it was agreed that there is no need to have a definition because the issues facing the underserved is about language and cultural competency. The Diversity’s work should be inclusive and consistent with SCAODA. For example, a few things the Diversity Committee needs to do to ensure language and cultural competency for underserved populations are:

1. CLAS Standard Presentation – ask Evelyn Cruz to do a presentation to SCAODA and highlight what are the new changes in the CLAS Standards, what are the general CLAS Standard requirements, what are the requirements for providers, and what does DHS need to do to enforce the CLAS Standards?
2. Update the CLAS Standards on the SCAODA website – the CLAS Standard information listed in the SCAODA website is the old version. We need to update it with the most current CLAS Standard version.

Cathy shared that for members who would like to take a tour at the May 8 meeting, she will need personal information such as a name, birthday, and address. Please send this information to Mai Zong.

OTHER

Data Collection Questions for Mike – What kind of data information should Mike present at the July meeting for this committee? Suggestions included: county, race, and age. Eventually, this group may want to conduct focus groups to generate data for the underserved population. A provider's list should be developed as well.

Meeting Time Change: It was discussed if the meeting time for the Diversity Committee should start earlier? It was agreed to keep it the same time.

Adjourn: Cathy made a motion to adjourn the meeting at 3:03 p.m. Sandy seconded it.

Meeting Minutes taken by Mai Zong Vue; 608-266-9218



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

DIVERSITY COMMITTEE MEETING

March 30, 2015; 10 a.m.

Special meeting on the Governor's Budget
Madison, WI

Meeting Minutes

By phone: Anthony Harris, Cathy, Gail Kinney, Denise Johnson, Sandy Hardie, and Thai Vue

Staff: Mai Zong Vue

Meeting Called to Order: Thai called the meeting to order at 10:03 a.m.

Governor's Proposed Budget:

Denise asked if the Committee received clarification about the Badger Care waiver question asked during the February meeting. No, not yet.

After some discussion a motion was made as follow on the Governor's Proposed Budget.

The Diversity Committee

- Support the opposition of the drug test for FoodShare Employment and Training recipients and childless adults on Medicaid for illegal drugs because it is not equitable
- Support the Expansion of Medicaid to cover the treatment portion of residential substance use disorder treatment
- Oppose the creation of a pilot treatment program for offenders with an opioid addiction-related conviction because the cost is expensive and would like to see this money be earmarked for substance abuse treatment for offenders.

The motion was made by Gail and seconded by Sandy. Cathy abstained.

Sandy made motion to adjourn the conference call meeting and seconded by Gail at 10:30 a.m.

Meeting Minutes taken by Mai Zong Vue; 608-266-9218



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

DIVERSITY COMMITTEE MEETING

April 10, 2015; 9:30 a.m. – 2:30 p.m.

Chippewa Valley Technical College

615 W. Clairemenont Avenue

Eau Claire, WI

Meeting Minutes

Present: Gail Kinney, Thai Vue & Denise Johnson

By phone: Cathy Scheier, Richard Byrant & Anthony Harris

Staff: Mai Zong Vue

Guests: interpreters and 15 students from Gail's class

Meeting Called to Order: Thai called the **meeting to order at 9:47 a.m.** (no speaker phone available initially) Thai welcomed our new member, Mr. Richard Byrant. Richard introduced himself and briefly shared what he does for a living.

Public comment: none

Students went around and introduced themselves to the Committee!

Minute minutes: The February 20, 2015 and March 30 special budget meeting minutes were approved as submitted. Motion was made by Gail and seconded by Denise.

Website Student Recruitment updates: Gail shared that she made efforts to recruit but did not hear from any students. A question was asked about the SCAODA website—can DMHSAS staff update the Diversity page? Mai Zong checked with DMHSAS--Yes, staff (Ashleah) can update Diversity link as much as possible. However, DMHSAS is moving into a new program next month and staff may not be able to update it regularly.

Diversity Workshop: A great discussion was held. Gail made the motion to approve the workshop title and seconded by Cathy. The workshop title is: **The Difference is You!**

Workshop description should include: To help people become more competent while they need to do some work themselves. What are the things that service providers need to do in order to deliver cultural competent services? How do you teach students to be culturally competent? What is effective and what is not when serving underserved populations? What are some considerations you need to consider when working with this a diverse population? Diversity awareness is the goal for the workshop!

The workshop panelists will be Thai, Denise, Cathy, Tina and Gail. It was agreed that Mai Zong will formulate a description and send to everyone for comments.

CLAS Standard presentation: The Committee discussed in length when should the CLAS Standards be presented to the full Council. After much discussion, it was agreed that the Committee ask Evelyn Cruz to present the CLAS Standard to SCAODA in September and delay the Diversity's presentation to SCAODA to March 2016.

Reports and Data Reviewing: The Committee reviewed these reports: 2014 DMHSAS Service Delivery Data; 2013 Youth Risk Behavior Survey Result; Healthiest WI 2020 Baseline and Health Disparities Report Alcohol and Other Drug Use; the DMHSAS's 2012-2014 Performance Report; and the 2014 WI Epidemiological Profile on Alcohol and Other Drug Use

Some comments generated from the report and data review discussion included:

- Who does the reporting, who decides what to report, what are the % of population reported and the % of services?
- Deaf and hard of hearing—there is no data available on the reports at this point event though we know some services were provided. There are a lot of gaps in serving the underserved populations, for there is no user friendly services (this is much needed), agencies don't know how to find interpreters, and agencies don't know what is happening in the community.
- Lack of insurance coverage--there are people who are not receiving services due to lack of insurance coverage, especially private insurance. Detox treatment is not covered.
- Interpreter challenges: Patients can get to the door of a clinic but once inside there are no interpreters available. As a result, patients were required to meet in group in order to receive information and services.
- At DMHSAS, how many resources are allocated for special needs populations? Who and how many people are accessing services that have insurance coverage?
- Reports are great but we need to be more proactive in addressing the issues. For example, reports such as the Healthiest Wisconsin 2020 Baseline and Health Disparities Report comes out every ten years...we know the problem that are listed but we don't do much on addressing the issue. In addition, in YRBS report, do the students understand the terminologies or definitions used...such as the word "weapon."

The Committee agreed that they will need time to digest and absorb the information and organize their thoughts. At the next data review session, the goals for the data reviewing discussion are to see where the gaps are, identify what data is useful and not, and share the information with the Council.

A question was asked if the letter to Michael regarding DSPS letter was sent out. Mai Zong will follow up.

It was shared that the Governor will merge DSPS and Dept. of Finance together. There are ongoing concerns regarding access to training and licensure for minority counselors. The Committee will review this issue again at the May meeting.

Reminder—anyone wishing to take a tour of the Fox Lake Correction Institute on May 8 should send their name and birthday info to Cathy. Also, the tour involves lots of walking--come with your walking shoe!

Next meeting agenda item

- Merging of two departments
- Data discussion & next steps
- CLAS Standard updates
- MH/SA Workshop updates
- Tour of Fox Lake Correction Institute

Thai thanked the students—*thank you for coming, taking your time to listen to us, experience a public committee at work*—for their time.

Gail made a motion to adjourn the meeting at 12:09 p.m. and seconded by Denise.

Meeting Minutes taken by Mai Zong Vue; 608-266-9218



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

DIVERSITY COMMITTEE MEETING

May 8, 2015; 9:30 a.m. – 2:30 p.m.

Fox Lake Correctional Institute
W10237 Lake Emily Road
Fox Lake, WI 53933; 920-928-6953

Please call Mai Zong Vue at (608) 266-9218 or e-mail maizong2.vue@wisconsin.gov if you cannot attend.

Call in telephone number: 1-720-279-0026 or 1-877-820-7831

Participant Passcode is 408162

- | | |
|------------|---|
| 9:30 a.m. | Call to Order & Introduction – Tina Virgil, Chair
Public Comments
Approval of April 10, 2015 meeting minutes
MH/SA Conf—review of Diversity Workshop Description |
| 10:00 a.m. | <ul style="list-style-type: none">• Fox Lake Correctional Institute TOUR• Website Student Recruitment updates - Gail• CLAS Standard presentation Updates• WI SA Needs Assessment - 2015 Update• Reports & Data Reviewing Discussion |
| 12:00 p.m. | Lunch (decide on lunch options) |
| 1:00 p.m. | Report and Data Discussion cont.
SCAODA Presentation Discussion
Merger of two departments |
| 2:15 p.m. | Others
Agenda items for next meeting |
| 2:30 p.m. | Adjourn |

**NOTE: Next SCAODA meeting is June 5, 2015; American Family Insurance, Madison
Next Diversity Meeting is July 17, 2015; Independent Living Council, Madison**

Diversity Mission Statement:

To enhance and honor the lives of Diverse Populations of Wisconsin by providing access to culturally intelligent substance use related services.

SCAODA Mission Statement:

To enhance the quality of life of Wisconsin citizens by preventing alcohol, tobacco and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING

Tuesday, February 10, 2015

10:00am – 2:30pm

Department of Corrections

3099 E. Washington Ave.

Room 1M-M

Madison, WI

MINUTES

Present: Norm Briggs, Roger Frings, Dave Macmaster, Tanya Hiser, Lucas Moore, Staci McNatt, and Andrea Jacobson (staff).

Absent: Steve Dakai and Dan Nowak.

Welcome, Introductions and Review of Minutes – Mr. Briggs called the meeting to order at 10:13 a.m.

Mr. Frings made a motion to approve the January meeting minutes; Mr. Macmaster seconded. No oppositions or abstentions. An amendment was proposed to make a few corrections and was voted on, and approved.

Public Comment – None

Section and Committee Updates

Children, Youth and Family – Mr. Moore provided an update re: the sub-committee schedule and asked for a review of the goals and objectives for this sub-committee. At this time, 14 individuals have been invited to join the sub-committee. Ms. McNatt will also be joining the sub-committee and Mr. Macmaster wondered about inviting someone with a primary prevention perspective from one of the WI coalitions.

A review of the original concerns which led to the formation of the CYF sub-committee occurred along with discussion of goals. Per Mr. Briggs, it seems that while the need for adolescent substance abuse treatment facilities is increasing the resources are dwindling. For youth, in particular, being able to access treatment in the community they reside is important and leads to more successful outcomes. If a youth is being sent out of the community, the discharge planning

and prompt, warm handoffs to ongoing services providers is critical. It is unclear to the ITC committee why adolescent specific treatment centers are closing; is it due to lack of referrals or funding or something else? The following goals were identified for the CYF sub-committee:

- 1) Determine WI's current availability of treatment for Substance Abuse services to adolescents across levels of care, including residential. Discussed ways to obtain the data including:
 - a. The Youth Risk Behavior Survey (which was handed out and briefly reviewed during this meeting). It was hypothesized that youth may not be seeking services as they are already aware of the lack of available services.
 - b. Project Fresh Light: This resource listing is still in place but uncertain how frequently updated.
 - c. Researching other possible resources for treatment listings.

- 2) Obtain data on prevalence of substance use disorders for youth along with the need or demand for substance abuse treatment services:
 - a. Interview adolescents in treatment – how referred and why choose that facility
 - b. Hold focus groups
 - c. Call large HMO's to determine how they are responding to youth with SA needs– where are they sending for residential/inpatient. Per Roger – basic plans do not include residential care. Are there insurance limitations which impact resources?

- 3) Survey the active adolescent treatment centers to determine why they are apparently underutilized:
 - a. What barriers are they facing in attempting to provide treatment to youth?
 - b. How and from whom do they obtain referrals?
 - c. What are their funding sources?

- 4) Explore modalities for dispensing adolescent specific treatment resource information out to the public, in settings where families/students can readily access.
 - a. Distribution of paper booklets with listing of treatment resources at: doctor's office, community programs, treatment schools such as New Horizon's, and via WI Alliance for Youth Prevention Coalitions.
 - b. Collaborate with Rise Together as they are going into the schools and increasing motivation for youth to seek treatment services, but are in need of referral sources for treatment in local communities.
 - c. Perhaps town hall meetings with schools.

- 5) Develop a report which reviews what the data shows and identifies recommendations for addressing gaps, areas of need, and suggestions for community or statewide collaboration.

A discussion of resources occurred: It was shared that Rosecrance from Illinois and now in southern WI is accepting WI medical assistance. In Dane County the Parent Addiction Network is offering support and education to families. It was noted that per many public school systems, if a staff person is concerned about possible substance use for a youth, they are only allowed to refer to a PCP, not to a substance abuse treatment provider.

Mr. Moore mentioned working on updating DHS website which will hopefully have links to resources. In addition, he informed the committee of current work in Rock County to train school staff in SBIRT in order to hopefully divert youth from correction via school intervention.

Treatment for Women and Their Children – Mr. Briggs provided an update regarding the SCAODA motion requesting to form a workgroup with DCF and SCAODA to explore ways to increase identification and treatment of substance use disorders with parents involved in child protection services. Per a joint letter from DHS and DCF, instead of forming a new committee, they are inviting a SCAODA representative to join the DCF advisory council meetings as a method for adding a primary substance abuse perspective.

Heroin/Opiate Treatment –

The committee reviewed the discussion from the January meeting regarding identifying objectives for moving forward in addressing the Opiate specific treatment needs in WI.

- 1) Gather Data: Review how many methadone clinics, and determine number and location of Suboxone. Explore ways to determine how many individuals are seeking Methadone/Suboxone and unable to access care due to wait lists or other barriers.
 1. What we already know:
 - a. Per SAMHSA 200 certified prescribers in WI
 - b. 6600 people received methadone services in 2013 (700 in Madison)
 2. We could send out a survey to current Suboxone prescribers regarding their experiences and perceived barriers to prescribing Suboxone.
- 2) Focus on how to incentivize new prescribers to become Suboxone certified.
 1. Collaborate with the medical society.
 2. GLATTC is providing annual trainings for physicians re: Buprenorphine. WI state could offer payment to Docs
 3. Develop a system to provide prescribers with a case manager/clinician who will track the patients on the caseload (case managers with peer specialist support).

- 3) Provide training to HMO case managers on the way to support opiate addicted persons – so that HMO case managers can provide the back-up to their own docs using SBIRT and call-backs to monitor for diversion.

Additional comments: Per Mr. Macmaster – ITC could make a recommendation that every program medical director needs to become Suboxone certified. Suboxone is allowed for individuals who are 16 and older, however for Methadone must be 18 yrs. of age.

PLANS:

- 1) In order to obtain additional information regarding the issues of MAT prescribing, Mr. Briggs is seeking out a presentation by a community prescriber and Ms. Hiser is coordinating a presentation by a Methadone clinic prescriber (Mr. Briggs will provide specific questions for the presentation to Ms. Hiser).
- 2) Explore making a motion to add a physician member to SCODA – this may require legislative action, although per a past motion ITC may be able to work with Planning and Funding Committee.
- 3) Ms. Hiser will check with Mike Quirke of DHS to see if data exists regarding opiate specific treatment to help identify the demand or need for treatment (size of the population).
- 4) Ms. Jacobson will explore developing a map with an overlay of Suboxone providers in WI.

Affordable Care Act Implementation Update – The website now allows comparison of health care rates for insurers providing plans (2012 – 2015). The deadline is 2/15/15 for signing up. Per Ms. McNatt – she has been informed of a gap in care for those individuals obtaining SSDI as they are being denied coverage for the first year. Mr. Frings will look into this further.

Ad Hoc Committee on Workforce Development – Duncan Shroud and Bernestine Jeffers provided an overview of the drafted report. Mr. Novak was not available today. Per the report the following general recommendations are being made:

- DSPS to create a peer review committee to review all applications and advise in certification standards.
- .5 FTE position at DHS to assist all applicants with certification.
- Grandfathering the current workforce in good standing from being required to perform new educational requirements as added to certification procedures. So if advanced degrees become required, not to require for already certified.
- Medicaid reimbursement rates be increased.
- DHS to work with educational and training institutes to develop a SAC recruitment system.
- Develop a formal workforce plan: conduct and environmental scan, update the statewide survey of approved programs for SAC's, update the 2012 SAC survey and develop a WI career ladder by using the national and adapt to WI (including clinical supervision and all positions recovery coaching/Peer support).

A decision was made to add a review of the report to the April ITC meeting in order to determine the depth of: data inclusion, background of concerns including historic organizations working on workforce (WAAODA), reason for specific recommendations vs. others, etc... Mr. Shroud mentioned that the report could provide more geographical specific workforce deficits and/or regarding barriers caused by lack of financial compensation comparable to other health field positions.

PLAN: The Ad-hoc workforce committee will make some of the revisions mentioned and submit back to ITC in 30 days in order to review for final draft decisions in April meeting.

WINTIP – Mr. Macmaster provided a handout (attached to minutes) and reminded committee members of his goal to work towards ending discrimination against tobacco, by equalizing treatment options. He shared examples of successful state legislation in New York; under rule 856 must be tobacco free and include tobacco treatment services in substance abuse treatment programs. There was 70% compliance the first year and 90% compliance the second year (it's been in effect for 8 years). The state used language which was flexible allowing individual program implementation planning. New Jersey lessons learned report cited positives of tobacco cessation integration: save lives, reduce triggers for use, decrease those being exposed and developing tobacco addiction, easily incorporated into substance abuse treatment programs.

Mr. Macmaster also shared that movement for equality of tobacco treatment services is occurring in other counties, citing a Canadian province that is currently seeking a waiver to allow a tobacco treatment program to serve tobacco as a primary disorder.

The discussion then went to determining what motion Mr. Macmaster is seeking. Mr. Macmaster clarified that he is asking for a motion that requests "SCOADA to draft a letter seeking legislation to remove language in DHS 75.86 Administrative Rule which states "excluding nicotine dependence". Mr. Macmaster believes this language limits treatment agencies from serving clients with tobacco use disorders as sole or primary diagnosis.

Mr. Briggs was uncertain that DHS 75.86 is indeed restricting treatment providers from serving individuals seeking treatment for tobacco cessation. He asked if it is known that any individuals have not been allowed to access treatment for nicotine as a primary diagnosis, or if any agencies have been cited for serving nicotine as a primary diagnosis.

PLAN: Ms. Hiser expressed support for WI being a leader in treating nicotine addiction and is interested in developing a motion, if indeed the language is limiting provision of treatment services. Ms. Jacobson agreed to explore the interpretation of DHS 75.86 with the DHS 75 Interpretation Committee which includes DQA staff. Mr. Frings requested exploration regarding any financial implications of changing the DHS 75 Administrative Rule language. Mr. Briggs wonders if more education is needed for SCAODA in order to move a motion forward and discussed the possibility of presenting new information to SCAODA.

Updates: Per Mr. Macmaster, there are now three nicotine anonymous meetings in the Madison area and a new 12 step study workbook was developed to specifically work with nicotine use disorders.

Future Agenda Items:

- April – review workforce report and outline what we want added or revised. The goal is to share with full SCAODA in the Sept meeting.
- Presentation by Medication Assisted Treatment experts.
- Ms. Jacobson to seek out consultation with the DHS 75 interpretation committee re:
 - The language making nicotine an exception to “substances” (DHS 75.01(86), is there any history to know if this is an assumed oversight that needs updating or intentionally limiting nicotine as a primary diagnosis.
 - Seek recommendation of an expert who could determine if there financial ramifications for updating this language to exclude the nicotine exception.
 - Ask DQA if an individual is presenting at a facility for tobacco use dx only, would they be turned away as a publically funded agency. If not, would DQA cite the agency if the person were admitted.

Mr. Frings made a motion to end the meeting and Ms. McNatt seconded. Motion was approved and the meeting was called to an end by Mr. Briggs.

Next meetings and dates:

- **SCAODA – March 6th, 2014; 9:30 am – 3:30 pm; American Family Insurance Conference Center, Madison. For more information, visit the SCAODA web site at: <http://www.scaoda.state.wi.us/meetings/index.htm>**
- **ITC – April 14th, 2015; 10:00 am – 2:30 pm. Department of Corrections, Madison**

Future 2015 Meeting Dates

April 14th
May 12th
July 14th
August 11th
October 13th
November 10th

Full SCAODA meetings will occur on March 6th, June 5th, September 11th, and December 11th.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING

Monday, March 16, 2015

10:00am – 11:00 am

Phone Conference Call

MINUTES

Present on Phone: Norm Briggs, Roger Frings, Dave Macmaster, Tanya Hiser, Staci McNatt, Lori Cross Schotten, and Andrea Jacobson (staff).

Welcome and Introductions

Reminder of Purpose: For ITC to review the proposed budget in order to provide SCAODA with our comments from an intervention and treatment perspective.

Proposed Budget Items:

- DOT –
 - no comments
- DOJ –
 - no comments
- UW System –
 - no comments
- DSPS –
 - no comments
- DOC
 - Vivitrol Pilot: Difficult to fully comment as there is not enough detail in the proposal. ITC would like to emphasize the importance of treatment and continuing care and assisting individuals post release, in order to obtain insurance coverage for continued prescribing and therapy. ITC would recommend that this pilot include continuing care planning with medication and/or therapy for a 2 year period. One can reference methadone treatment standards which indicate continuing care for an extended period of time. The medication is only effective while actively being administered, and services need to continue post medication.

- DHS

- Expanding Medicaid to cover treatment portion of residential care:

Adding MA coverage for the therapy portion of residential care will help reduce County costs and accordingly ITC supports this proposal, with a caveat that the MA reimbursement should not supplant the current county funding streams – as the room and board would not be covered and would need reimbursement. The hope is that counties would not decrease current residential funding levels and instead could increase capacity.

- Keep AODA funding at \$14,500,000:

ITC would like to request a break-down of where this funding comes from, including the portion provided via alcohol taxes. This would not necessarily need to be provided prior to budget response. ITC is greatly concerned that the funding for AODA services is not being increased in order to meet increasing costs. ITC recalls a Planning and Funding Committee motion on 9.13.13, in which SCAODA was requested to send a letter to DHS requesting budget increases in order to plan for increased costs based on consumer price index. It is impossible to expect that counties and treatment providers can continue to operate biennium after biennium without financial increases to cover increasing cost of business and cost of living increases.

- Pre-trial IDP Transfer from DOT to DHS:

It appears that the currently available funds will either be staying with DOT or ending. ITC would like to obtain information regarding the outcomes from the pilot as this could provide valuable information regarding continuing to fund these programs. PLAN: Andrea will contact LeeAnn Cooper to determine if outcome data is available. No comment until the outcome data information is available for review.

- Drug Testing for recipients of benefits:

- Concerns: Lack of detailed information, but it appears that only DWD contains funding for treatment and this should be included for all persons undergoing testing requirements. In addition, it is unclear if funding is available for screening, intervention and the full continuum of treatment care. It is critical that services be readily available once a substance use disorder is identified, and without appropriate funding wait lists or lack of

available treatment may exist. Per Norm – when W2 was first proposed the proposal included nothing to address substance use disorders. SCAODA recommended that something be done to offer treatment services in order for individuals to succeed in the workforce. Funding intervention and treatment is crucial for the success of implementing a protocol to identify and address substance use disorders for those receiving assistance from the state. Research shows the effectiveness of SBIRT as a model of identifying and intervening using a motivational approach. It is unlikely that drug testing alone without a proven screening and intervention model will not be as effective.

Recommendation:

- Early identification of substance use disorders is an important initiative for everyone in our community. We recommend an SBIRT model of screening and intervention, possible including a drug testing component, in order to help these individuals to obtain services in order to reach recovery and stability.

Public Comment – None

Next meeting dates:

- **ITC – April 14th, 2015; 10:00 am – 2:30 pm.** Department of Corrections, Madison



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING

Tuesday, April 14, 2015

10:00am – 2:30pm

Department of Corrections

3099 E. Washington Ave.

Room 1M-M

Madison, WI

MINUTES

Present: Norm Briggs, Roger Frings, Dave Macmaster, Lori Cross Slotten (by phone), and Andrea Jacobson (staff).

Absent: Steve Dakai, Dan Nowak, Tanya Hiser, Staci McNatt, Alan Frank, and Lucas Moore,

Welcome and Introductions – Mr. Briggs called the meeting to order at 10:15 a.m. after a delay due to technical assistance problems. Due to a lack of quorum, set aside review and approval of past minutes.

Public Comment – None

Presentation by Dr. Matt Felgus on Adolescents and Opiates – Dr. Felgus reviewed receptor sites associated with opiate use and shared that all animals, including humans, have opiate receptor sites. Opiates decrease the arousal that goes with pain, but doesn't alleviate the pain. The pain relief aspect has led to Opiates being prescribed for mood disorders and some experts are now recommending use of ketamine as an anti-depressant, but the risk of addiction seem to outweigh the benefits. He shared that benzodiazepines are dangerous when mixed with opiates.

Dr. Felgus highlighted that many doctors do not have training in addiction. This fact, combined with the fact that many patients naively believe that everything which is prescribed to them is good for them, can contribute to the risk of developing a SUD.

When treating adolescents with opiate use disorders, Dr. Felgus commonly is finding anxiety, insomnia, trauma or other co-occurring or underlying concerns. Dr. Felgus finds that asking youth "What does the substance do for you?" is a key to treatment. He tends to believe that for the majority of adolescents a genetic vulnerability combined with high stress levels, leads to SUD's. Because of this fact, he promotes that the medical and dental field always inform a

person being prescribed an Opiate that “This is an addictive medication, and if you really feel good and love the effects of this pain medication, it means that you likely have a genetic vulnerability to addiction”. He also feels it is critical for prescribers to use the Prescription Monitoring Program.

Dr. Felgus noted that with youth, depression is often overlooked. Instead of displaying melancholy, they tend to behaviorally act out. Youth also lack a vocabulary and/or ability to talk about depression. Substance abuse and depression lead to a higher risk of self-harm and suicide. If psychosis is present, whether an underlying condition or caused by SUD, it still needs to be treated and can last longer than the drying out or withdrawal period. Individuals with anxiety and SUD have a higher likelihood of panic attacks. Anxiety is a primary symptom of opiate withdrawal and resuming use of opiates absolutely works to make a person feel better. Dr. Felgus highlighted the importance of treating these issues or the risk of relapse become too great.

The DSM listing of symptoms for anxiety and withdrawal look the same as the majority of symptoms are the same. Dr. Felgus tries to look for physical evidence of withdrawal; goosebumps, sweating, etc... as it is the only true way to differentiate withdrawal and anxiety. During treatment, Dr. Felgus always educates individuals on anxiety and withdrawal. In regards to when to treat anxiety, Dr. Felgus does not believe that a person needs 6 months, or a significant period of abstinence, as if you don't treat the anxiety, the person won't be able to get to 6 months clean.

Opiate replacement therapy (ORT) is effective in reducing opiate use and works best when combined with SUD therapy. Some prescribers continue to increase the levels instead of offering therapy – worsening the addiction. There is a concern ORT with a young person, further establishes a dependency. Need extra caution in determining who should be offered this option, and typically Dr. Felgus would require a significant history of opiate use, and rule out other modes of treatment first. If a person already has an opiate dependence they will not get a high from the medications – but for occasional users without an addiction, a medication such as, Suboxone will get them a high. He acknowledged that there is a lot of controversy on methadone. Methadone tends to be is a long drawn out process – so for a youth, who is only using low level of pain meds this medication would not be recommended, as Methadone would be increasing the problems vs. helping. He requires that a person needs to have a minimum of one year opiate use to consider methadone as the medication of choice. His impression is that this is not always required by methadone prescribers at this time.

Dr. Felgus reported that he believes there is somewhat less success of ORT with the under 18 population. Per his knowledge, all insurance plans cover ORT. The average length of Suboxone treatment is 3 years. The average half-life of the medication is 35 hours, so typically no need to split up doses, however, for pain conditions some patients do need to take it more than once a day.

In conclusion, Dr. Felgus made the following recommendations:

- a. Educate clients/patients re: anxiety and withdrawal (time frames and symptoms)
- b. Use non-addictive meds for anxiety
- c. Teach other coping strategies; relaxation, yoga, meditation, exercise, etc...
- d. Mentally preparing the individual for withdrawal
- e. Slow step-down process (with warning about how emotions may be effected).
- f. Choose timing carefully (if high stress wait)
- g. A long term continuing care plan (minimum 1-2 year withdrawal time period)
- h. Sometimes need to step- up recovery work as weaning down medication
- i. Films are better than pills as they can be split to smaller amounts during the weaning process (his patients request dropping by 1/8th).

Section and Committee Updates -

Children, Youth and Family: No update (Mr. Moore was unable to attend today's meeting).

Treatment for Women and Their Children: Mr. Briggs brought up DHS's initiative to explore diversity and cultural intelligence/competency with a group of women's treatment providers. Plan to have a northern and southern two day meeting to: develop common language, discuss ways to approach services provision with cultural sensitivity, enhance outreach and work across diversity to help tackle disparities in Wisconsin and to develop a white paper at the conclusion of the two events.

Heroin/Opiate Treatment: Reviewed data provided by Ms. Hiser, from Mike Quirke at DHS, re: need for Opiate treatment by Wisconsin citizens. The data represents those seeking or reaching out for services, but is it not known how to identify those with a "need" for services who yet to reach out to the treatment community. We know there is a substantial group of individuals in need of treatment services, but not at a point where they are ready or willing to seek services. Per Mr. Briggs, Dane County appears to have treatment services available to meet demand of those seeking services, from a capacity perspective. It would be helpful not only to the individuals themselves, but for the community as a whole, if those with a need for treatment would reach out for services. Discussion of how family members may be ready for help but the identified person with a Substance Use Disorder (SUD) may not be willing. Per Ms. Cross Slotten, as a recovery coach, she finds it important to help an individual develop a recovery plan and noted that often people know about 12 step meetings or treatment, but aren't ready or willing to walk-in without support. She is also aware of many persons with SUD's who did not seek insurance on the exchange, as this wasn't an active priority, and accordingly face barriers in obtaining treatment. Another barrier for obtaining services is that families tend to get burnt out or tired of trying to assist the individual with a SUD. Some areas in the state have supports for families and this is beneficial.

Ad Hoc Committee on Workforce Development : Delay in reviewing the report draft due to scheduling; now planned for May 12th ITC meeting. Broad discussion of including in the report the committee members, who was consulted and what data was gathered during the development of the report (resources) and further depth regarding how recommendations were developed.

WINTIP: Mr. Macmaster provided a handout (attached to minutes). He provided the following updates:

- UW is receiving a grant to develop video webinars for education about nicotine treatment and program development for providing nicotine treatment services.
- Reminder of the upcoming transition from DSM V to ICD 10
- WiNTip is seeking a legislator to change the language in DHS 75 and would like ITC to propose this motion to work on this concern from multiple approaches. He submitted a revised motion for ITC to vote upon.

Future Agenda Items -

- Discuss proposal for a motion to SCAODA to add an addictionologist as a formal member of SCAODA (ex-officio).
- Ms. Jacobson to email out to committee members Mr. Macmaster's handouts and request a preliminary response to the Equity Resolution. At the next meeting, a vote will occur as long as a quorum is present.
- Review budget recommendations from SCAODA (handout)

Meeting adjourned at 12:18 pm.

Next meetings and dates:

- **ITC – May 12th, 2015; 10:00 am – 2:30 pm. Department of Corrections, Madison**
- **SCAODA – June 5th, 2014; 9:30 am – 3:30 pm; American Family Insurance Conference Center, Madison. For more information, visit the SCAODA web site at: <http://www.scaoda.state.wi.us/meetings/index.htm>**

Future 2015 Meeting Dates

April 14th
May 12th
July 14th
August 11th
October 13th
November 10th

Full SCAODA meetings will occur on June 5th, September 11th, and December 11th.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING

Tuesday, May 12th, 2015

10 a.m. – 2:30 pm

Department of Corrections
3099 E. Washington Ave.
Room 1M-M
Madison, WI

AGENDA

- | | | |
|-------|---|------------|
| I. | Welcome, introductions, and public comment | 10:00 a.m. |
| II. | Review of February, March and April minutes | 10:15 a.m. |
| III. | Review of the Ad-Hoc Workforce committee report | 10:30 a.m. |
| IV. | Lunch | 11:45 a.m. |
| V. | Discuss strategic recruitment of ITC members | 12:30 p.m. |
| VI. | Review of March SCAODA meeting/budget comments | 12:45 p.m. |
| VII. | Review of the: 2015 WI Substance Abuse Needs Assessment for comments | 1:00 p.m. |
| VIII. | Section updates | 1:15 p.m. |
| | ▪ Children, Youth, and Families (Lucas Moore) | |
| | ▪ Treatment for Women and Their Children (Norman Briggs) | |
| | ▪ Heroin/Opiate Treatment (Tanya Hiser) | |
| | ▪ Mental Health Council Criminal Justice Committee (Norman Briggs) | |
| IX. | WiNTiP (Dave Macmaster) – consideration of nicotine resolution/motion | 1:45 pm |
| X. | Develop motion on recommendation for Addictionologist on SCAODA | 2:05 p.m. |

- | | | |
|------|---------------------|-----------|
| XI. | Future agenda items | 2:15 p.m. |
| XII. | Adjourn | 2:30 p.m. |

Call-in Information:

Phone Number: 1-877-820-7831
 Passcode: 793544

Upcoming meetings:

ITC

- | | |
|---------------------------|--|
| July 12, 2015, | 10:00 a.m. – 2:30 p.m. DOC in Madison. |
| August 11, 2015, | 10:00 a.m. – 2:30 p.m. DOC in Madison. |
| October 13, 2015, | 10:00 a.m. – 2:30 p.m. DOC in Madison. |
| November 10, 2015, | 10:00 a.m. – 2:30 p.m. DOC in Madison. |

SCAODA

- | | |
|---------------------------|--|
| June 5, 2015, | 9:30 a.m. – 3:30 p.m. American Family Insurance Conf. Center, Madison. |
| Sept. 11, 2015, | 9:30 a.m. – 3:30 p.m. American Family Insurance Conf. Center, Madison. |
| December 11, 2015, | 9:30 a.m. – 3:30 p.m. American Family Insurance Conf. Center, Madison. |

SCAODA Motion Introduction

Committee Introducing Motion: Planning and Funding

Motion: Screening and drug testing for applicants for the public benefit programs listed in the governor's proposed budget should be implemented as a pilot program in a limited number of counties and in such a way that evaluates quality of life outcomes for participants, such as employability and control of the use of substances for individuals in various programs. Individuals who test positive must be further evaluated and have ready access to services to improve employability and control of the use of substances.

Related SCAODA Goal:

1. Provide leadership and direction on AODA issues in Wisconsin by serving as the voice to whom the Governor, legislators, local coalitions, and median turn for guidance on AODA issues and promote collaboration across multiple sectors to advance progress on SCAODA goals.

Related SCAODA Priority:

5. Increase the use of evidence-based practices in prevention, treatment, and recovery

Background: SCAODA opposes the drug-testing provisions in the proposed budget and in pending legislation. Recognizing that the proposals are likely to become law, SCAODA needs to exercise its statutory obligation to provide advice on how to best implement programs that affect substance use disorders.

Positive impact: There is no evidence that drug testing recipients of certain public benefits have improved life outcomes. This motion would be a first step in gathering data that can be used to implement an evidence-based drug-testing program.

Potential opposition:

- a. There is no evidence that drug testing recipients of those public benefits specified in the proposed budget improves the life outcomes for people with substance use disorders.
- b. There is evidence that the cost of drug testing recipients of those public benefits specified in the proposed budget may exceed any potential cost savings.
- c. There is no evidence that recipients of those public benefits specified in the proposed budget use illegal drugs at a higher rate than other recipients of public benefits or of the public at large.
- d. There is currently not enough treatment capacity in Wisconsin to provide substance use disorder treatment.

Rationale for Supporting Motion: SCAODA has the expertise to advise state agencies on best practices in implementing public benefit drug-testing programs. Because the proposals likely will become law, SCAODA needs to take a leadership position and guide the implementation of the program.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851

Madison, Wisconsin 53707-7851

PLANNING AND FUNDING COMMITTEE MEETING MINUTES

February 12, 2015

Members present: Todd Campbell, Steve Fernan, Tom Fuchs, Karen Kinsey, Joyce O'Donnell, Emanuel Scarbrough, Duncan Shrout, Sally Tess

Members excused: Irene Secora

Guests: Norman Briggs

Staff: Kris Moelter

Call to Order – Joyce O'Donnell the meeting to order at 9:38 a.m.

Review of November 21, 2014 meeting minutes – Duncan Shrout moved (Tom Fuchs second) to approve the meeting minutes. Motion passed unanimously.

Public comment – None.

Update from December SCAODA meeting – Ms. O'Donnell updated the committee on the December SCAODA meeting. The legislative study committee on problem-solving courts is requesting the legislature support the expansion of treatment alternative programs and treatment court programs. Nancy Michaud gave a presentation on the annual Synar Report, which showed the tobacco sales to underage people dropped from the prior year. The Department of Health Services Deputy Secretary Kevin Moore is now the state's Medicaid director. He will no longer represent DHS on SCAODA. The new DHS representative has not been determined. Lou Oppor reported that DHS will fund three regional opiate treatment centers in rural and underserved areas. The request for proposal was recently released.

Review proposed biennial budget and agency budgets – Kris Moelter distributed a chart with the AODA-related budget items from the executive budget, including items that agencies had requested but were not included in the budget. The committee discussed the items at length and decided to recommend SCAODA support the expansion of Medicaid to cover substance use disorder treatment in residential treatment centers.

Most of the discussion was on the proposal to drug test recipients of certain public benefits. The committee decided to recommend that SCAODA send a letter to the legislature opposing the drug testing proposal as set forth in the budget but also making recommendation on how to implement a program should the legislature decide it wants to pass that part of the budget. SCAODA should oppose drug testing because there is no evidence that it serves any purpose. The Florida program has been found unconstitutional. In Tennessee fewer than three percent tested positive and it cost the state more money to test than it saved. Testing also stigmatizes

people in the lower socio-economic brackets as drug users even though data show they do not use illegal drugs any more than people in other socio-economic groups.

If drug testing is going to become law, SCAODA should recommend some changes to the current proposal. Specifically, the testing should be expanded to all recipients of public benefits, not just low income recipients. It also should not sanction people who test positive for illegal drugs. Sanctions should only be imposed on those who refuse to be screened, take the drug test, or refuse treatment. Also, more money needs to be appropriated for treatment. There is currently not enough capacity to provide substance use disorder treatment, so more funds are needed if more people need treatment. The drug testing should also include alcohol because it is the most abused substance and more people need alcohol treatment than treatment for other drugs.

Ms. Moelter will send the committee members a summary of the discussion that will be included in the materials for the March SCAODA meeting.

AODA ad hoc funding committee – Todd Campbell reported that the committee looked at historical AODA funding and some existing AODA funding. At its next meeting the committee will identify service gaps and then look at how those gaps could be funded. The committee is focusing specifically on those programs and initiatives that relate directly to AODA. The committee will update this committee at the April meeting.

Committee and agency reports – Steve Fernan reported that 2015 Youth Risk Behavior Survey will be conducted this winter/spring. The survey retains the AODA-related questions so a trend analysis can be done. A preliminary report will be ready for the June or September SCAODA meeting. The Department of Public Instruction recently received four grants—one on improving school-based mental health services, one to research bullying; a school climate transformation grant, and an emergency management operations grant. In addition to addressing the specific goals of the grants, they will help increase the capacity for training schools statewide. DPI is in the process of awarding small AODA grants to school districts. It anticipates awarding 50, two-year grants.

Mr. Shrouf reported on the work of the Intervention and Treatment Committee's Substance Use Disorder Workforce ad hoc Committee. ITC will review the preliminary report at its April meeting and bring the report to SCAODA in September. The committee has made recommendations, subject to ITC review.

1. The Department of Safety and Professional Services (or its successor) should create a committee to review all applications for substance use disorder counselor certification and help the agency set certification standards.
2. DHS should create a .5 position to help people obtain substance use disorder counselor certification.
3. All certified substance use disorder counselors who are currently certified and in good standing will not have to complete additional educational requirements to remain certified.
4. Increase Medicaid reimbursement rates for substance use disorder counselors.
5. DHS should work with the educational institutions to develop a substance use disorder counselor recruitment plan.

Emanuel Scarbrough reported that the Prevention Committee's Marijuana ad hoc Committee has been meeting. The committee is focusing its work on four areas: legal/regulation, prevention, medical marijuana, and treatment.

Agenda items for next meeting – An update of the March SCAODA meeting; the workforce development ad hoc committee recommendations; an update on the funding ad hoc committee; an update on legislative and budget items.

The meeting adjourned at 1:20 p.m.

Next meeting: April 16, 2015 at 9:30 a.m. (THIS IS DATE CHANGE)

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Mary Rasmussen
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

**PLANNING AND FUNDING COMMITTEE MEETING MINUTES
March 26, 2015**

Members present: Todd Campbell, Steve Fernan, Karen Kinsey, Joyce O'Donnell, Duncan Shrout

Members excused: Tom Fuchs, Emanuel Scarbrough, Irene Secora, Sally Tess

Staff: Kris Moelter

Call to Order – Joyce O'Donnell the meeting to order at 3:32 p.m.

Review of February 12, 2015 meeting minutes – Duncan Shrout moved (Todd Campbell second) to approve the meeting minutes. Motion passed unanimously.

Discussion of proposed biennial budget – The committee reviewed the drug testing proposals in the proposed budget per the direction SCAODA made at the March 6, 2015 meeting. Steve Fernan made a motion that the committee recommend the Executive Committee oppose the drug testing proposals as set forth in the proposed executive budget. Mr. Shrout seconded the motion. The motion passed 4 to 1 (Mr. Campbell opposed). The committee agreed it would address the broader issue of drug testing in the workplace at a later meeting.

The meeting adjourned at 3:53 p.m.

Next meeting: May 1, 2015 at 9:30 a.m. NOTE: The April meeting has been cancelled.

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Mary Rasmussen
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

PLANNING AND FUNDING COMMITTEE MEETING

May 7, 2015

9 a.m.

DANE COUNTY HUMAN SERVICES BUILDING
1202 NORTHPORT DR., MADISON

Please call Kris Moelter at (608) 267-7704 or e-mail kristina.moelter@wisconsin.gov if you will not attend.

- 9 a.m. Call to Order – Joyce O’Donnell
- 9:05 a.m. Review of March 26, 2015, meeting minutes – Joyce O’Donnell
- 9:10 a.m. Public comment – Joyce O’Donnell
- 9:15 a.m. Update from March SCAODA meeting – Joyce O’Donnell
- 9:30 a.m. AODA funding ad hoc committee – Todd Campbell
- 9:45 a.m. Committee and agency reports – Committee members
- 10 a.m. Report on women’s services – Karen Kinsey
- 10:15 a.m. Needs assessment
- 11:15 a.m. Agenda items for next meeting
- 11:30 a.m. Adjourn

Next meeting: July 10, 2015



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

Prevention Committee
Thursday, January 15, 2015
9:30 am – 1:30 pm

State Bar of Wisconsin
5302 Eastpark Blvd.
Madison, WI 53718

Members Present: Scott Stokes, Ronda Kopelke, Irene Secora, Chris Wardlow, Annie Short, Kari Lerch, Julia Sherman, Sarah Linnan, Emanuel Scarbrough, Mary Rasmussen, Kathy Marty

Excused Members: Dorothy Chaney, Judith Hermann, Daniel Scott, Jane Larson, Francie McGuire-Winkler, Rick Peterson, Jackie Schoening

Guests: Shelia Simonsen and Lori Pesch

Staff: Louis Oppor, Christy Niemuth, Paul Krupski and Raina Zwadzich

Welcome and Introductions

Chairman Scott Stokes welcomed everyone and asked Members and Guests introduce themselves.

Public Comment

No comments from the public.

Approve Minutes from October 16, 2014 Meeting:

Scott asked Members to review meeting minutes and the Public Forum comments from the two sessions at the Substance Abuse Prevention training in Brookfield, WI. **Wardlow moved to approve the minutes, seconded by Kopelke. Meeting minutes were approved as drafted.**

Scott asked for a discussion on the items mentioned at the two Public Forums at the Regional Prevention Conference.

- Irene Secora asked for her name to be added to those in attendance at the public forum.
- Naloxone provision education for first responders has proceeded unfunded. A request should be made to the state to fund these efforts in order to save lives. This request will have to go to the Intervention and Treatment Committee.
 - Naloxone in the jail system has been extremely successful in reducing overdoses. A request was made to have Naloxone available at the state jails and treatment

centers. Progress has been made in this area with over 1,500 trainings being conducted on how to properly use Naloxone. There are efforts to provide these in the Milwaukee secured system.

- Best practices information on how to work effectively with the jail system would be useful. Kopelke, is thinking about how to incorporate the “Guiding Good Choices” program into the jail systems.
- Dane County is in collaboration with Journey Mental Health Center and is providing overdose education and Vivitrol®.

2014 Epidemiological Profile:

Members and Guests were provided copies of the new 2014 Epidemiological Profile. The priorities have stayed the same with a few some minor edits. The wording change was done in an effort to focus on behaviors rather than consequences.

Fact sheets based on the Profile will be created and disseminated through PFS II funding. The fact sheets are meant to supplement the Profile with information and data that could not fit into the final report. Some fact sheets that are planned are:

- LGBTQ
- Underage drinking, drinking and driving, binge drinking (Alcohol Awareness Month) - Julia Sherman offered her help in the creation of the underage drinking fact sheet.
- Women drinking during pregnancy and FASDs
- Sexual violence in college age students
- Veterans
- Older adults
- Suicide under the influence
- Overdose awareness week

Requests were made to produce fact sheets on ‘boating while under the influence’ and the ‘hunting season’ showing accidents and deaths attributed to intoxication. Sarah Linnan from UW PHI will look at the data. The boating data was not as significant as the data alcohol attributable snowmobile deaths.

Marijuana Ad-hoc Committee (MAC)

There have been four meetings of the MAC. Up until this point, the meetings have been largely focused on educating the Committee on key topics such as: legal issues, neuroscience, tribal treatment, prevention, and workforce issues. They have spent a lot of time sharing information from Members presenting on these topics. The Committee has a framework and will be working on revisions. The MAC has decided to change the language of ‘medical marijuana’ and will be proposing alternative language. The framework template was passed out to the Prevention Committee.

There are four workgroups Prevention, Treatment, Legality and Regulations and “Medical Marijuana”. MAC’s four Workgroups will be meeting in between the large MAC meetings. This will allow the Workgroups to have time to pull in key stakeholders, research, discuss and work on recommendations. The Workgroups will be participating by teleconference and if anyone

from the Prevention Committee would like to join a Workgroup please email Paul Krupski at paul.krupski@wisconsin.gov. Irene Secora requested to be added to the Prevention Workgroup.

Raina Zwadzich has pulled together the MAC's resources into a bibliography. The bibliography is becoming a great resource which will help other groups in locating research on marijuana.

PFS 2015 Funding Opportunity and Prescript Drug Abuse Prevention

The Strategic Prevention Framework Partnership for Success State and Tribal 2015 (SPF PFS 2015) Request for Proposal (RFP) was released in December. Only past recipients of SPF PFS II or PFS funding are eligible to apply for funds. Upon approval from DHS, Christy Niemuth will work on developing a proposal. The Prevention Committee will be the Advisory Committee for the grant should it be funded. Wisconsin will again be focusing on the prevention of prescription drug abuse. The grant is for 5 years of funding and it is due March 16th.

The RFP included the need to a) focus on the veterans populations and b) focus on suicide prevention efforts (Christy has reached out to Shel Gross of the Mental Health America – Wisconsin for input).

The PFS II will end September 2015 but because of underspending, DHS will be requesting a no cost extension for one year. If the no-cost extension is approved and the PFS 2015 is awarded, there would be overlap between the grants.

A Member requested to hear directly from some current PFS II Grantees about their work and prevention strategies. PFS II will be a standing agenda item on future Prevention Committee agendas. Kari Lerch and Annie Short from Milwaukee agreed to share information on their work related to the grant.

Lou Oppor and Scott Stokes provided an update on the National Governor's Association Prescription Drug Abuse initiative. They recently held their first stakeholder's meeting. There are a total of seven outcomes the Association has been working on. The next meeting is January 29th. Committees will be reporting out their findings on each of the seven outcomes. Many of the recommendations are about the PMDP and requiring participation from certain disciplines. The meeting is open to the public. The first half of the day will be with the stakeholders and national presenters and the second half of the day will be spent on recommendation work (there will be no opportunity to call in).

SCAODA Report Recommendation Strategy Grid

The SCAODA Report Recommendations Strategy Grid which was discussed and shared at the last Prevention Committee Meeting was discussed. It was decided to make the review of the grid a standing agenda item for Members to contribute activities that should be added to the document. Current discussion included:

- Will the new Attorney General continue to support and fund the Fly Effect campaign?
- Ronda Kopelke would like to collect information on local community campaigns by conducting a Survey Monkey poll. Responses could then be added to the grid.

Prevention Training 2015

There will be a statewide Prevention Training this year at the Kalahari Resort on June 11 & 12. For future trainings, there will be a statewide conference every odd year and regional trainings on the even years. There is a small Planning Committee made up of coalition members from each of the AWY regions. A survey was created to solicit training topics and sessions from stakeholders.

The draft Prevention Training session grid was shared with the group. There are open spots in the grid as a place holder for session proposals solicited from prevention providers around the state. The request for session proposals was emailed out to several key community holders and agencies. They are due February 13th through online submission. The Planning Committee will be reviewing the session proposals and make selections based on the top rated sessions. Speakers are currently being confirmed, but two Keynote Speakers have been selected; Ann Dowsett Johnston will speak on the issues of women and drinking and drinking during pregnancy and Montee Stiles, a retired prosecutor, will be speaking on drug prevention, specifically marijuana prevention.

Information on the Prevention Training can be found on the Stevens Point Continuing Education webpage. The AWY Regional Centers will be offering scholarships to their coalitions to attend the Training. Registrations are scheduled to go live on April 1st along with detailed session descriptions.

Feedback from the regional trainings in 2014 included:

- Coalition members really appreciated the Brookfield Training
- Northwoods made charts of their satisfaction with the training, Ronda will forward
- Local presenters were used, popular and respectful.

UW-Steven's Point is recruiting possible exhibitors. The cost of exhibiting has not been discussed yet. Once it has, Paul will share the information with the Prevention Committee. A request was made to have a room for a recovery meeting on the night of June 11. Other possible Training topics and exhibitors discussed among Members and Guests included:

- Tanya Hiser – State Methadone Authority
- Trauma Informed Care – Scott Webb
- CADCA – people love them and they always receive good ratings
- Funding opportunities
- DFC Grantees, or someone from SAMHSA
- Something to re-energize the field
- Science of Addiction – Krista Lisdahl, Flo Hillard, Dr. Galbis Reig, Dr. Miller

Agency/Member Updates

Scott Stokes shared that ARCW will merge with the AIDs Network on February 1st. All positions will be maintained between the two agencies with only one employee retiring. This is an exciting new adventure because they will be able to offer more services and treatment for individuals.

Julia Sherman shared an info-graphic poster about the alcohol problem in Wisconsin. The PDF of the poster can be found on the University of Wisconsin Law School – Wisconsin Alcohol

Policy Project website. If you like hard copies of the poster please email Julia and she will mail you copies.

A bill was recently introduced that would allow refillable growlers to be sold in grocery stores. Julia would like the Committee to take action on the bill. Christy requested that Julia send the information to her and she will send it out the Members. If there is an action that needs to take place before the next meeting in April she believes the Executive Committee can take that action.

Ronda Kopelke updated Members on an exciting new venture that CCO-Northwoods is taking on to increase volunteerism. They are currently working on strategic planning and are seeking members for a Steering Committee who are passionate and would have a strong voice in the prevention field. Contact Ronda if you are interested.

Future Meeting Dates/Agenda Items

Thursday, April 16, 2015

Thursday, July 16, 2015

Thursday, October 15, 2015

Standing Agenda Items

- Workforce Issues
- PFS II advisory committee
- Recommendations Report (Christy will email it out)
- Presentation on SBIRT at a future meeting
- A training on behaviors of kids who have been traumatized

Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Mary Rasmussen
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

Prevention Committee Meeting

Thursday, April 16, 2015

9:00 a.m. – 12:00 p.m.

(Note Time Change)

State Bar of Wisconsin

5302 Eastpark Blvd.

Madison, WI 53718

Agenda

- Welcome and Introductions
- Public Comment
- Approve Minutes from January 15, 2015 Meeting
- Promoting Alcohol Awareness Month – Fact Sheets
- Prevention Specialist Job Descriptions/Expectations
- Marijuana Ad-hoc Committee
- PFS II Update
- Prevention Training 2015
- Agency/Member Updates
- Future Meeting Dates/Agenda Items

Thursday, July 16, 2015
Thursday, October 15, 2015

RECOMMENDED PRIORITIES BY COMMITTEE
NOT in order of importance

Diversity

- Addressing disparities
- Addressing marijuana use among adults
- Tying the CLAS standards to funding for substance use disorder treatment
- Addressing difficulties obtaining substance use disorder workforce licensure

ITC

- Addressing the declining use of residential and intensive outpatient services
- Funding is not meeting the increasing costs of providing treatment services
- Addressing the widening gap between services offered and services needed
- Addressing substance use disorder workforce issues
- Addressing medication-assisted treatment

P&F

- Addressing youth and adult binge drinking
- Addressing access to alcohol
- Implementing SBIRT
- Improving quality of care and outcomes
- Addressing prescription drug abuse
- Addressing intravenous drug use issues

Prevention

- Addressing trauma and its impact on substance use disorders
- Developing evidence-based interventions
- Need a state-supported infrastructure to train substance use disorder counselors in evidence-based interventions and practices



STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health and Substance Abuse Services

Wisconsin

Mental Health and Substance Abuse

Needs Assessment Update

May 2015

Table of Contents

Executive Summary.....	3
Mental Health Summary.....	3
Substance Abuse Summary.....	4
List of Tables	5
List of Figures	6
Introduction	7
Needs Assessment Update	7
I. Prevalence.....	8
Mental Health Prevalence	8
Substance Abuse Prevalence	10
II. Access to Services	16
Number of Mental Health Consumers Served.....	16
Geographic Disparities in Access to Mental Health Treatment.....	17
Access to Crisis Services through the County System.....	19
Barriers to Accessing Mental Health Treatment – the Consumer Perspective	19
Substance Abuse Consumers Services and Gaps.....	20
Disparities in Substance Abuse Treatment.....	21
Substance Abuse Treatment – the Consumer Perspective.....	22
III. Service and Workforce Capacity	23
County Mental Health Services.....	23
Status of Efforts to Increase Capacity.....	27
Certified Peer Specialists.....	27
County Substance Abuse Services	30
Wisconsin and National Service Distribution.....	34
Detoxification Services.....	34
Medication-Assisted Treatment	35
Substance Abuse Treatment Workforce.....	35
Substance Abuse Service Availability and Waiting List Issues	36
IV. Quality and Outcomes	37
Quality and Appropriateness of Services.....	37
Consumer Outcome Indicators	48

Executive Summary

The purpose of this 2015 update to the 2014 Mental Health and Substance Abuse Needs Assessment report is to present and analyze more recent data to determine if any significant changes occurred in key data that could affect the selection of priorities identified in the FY 2015-2016 federal substance abuse and mental health block grant application. Those priorities in the previous MH/SA Block Grant applications included:

- Tuberculosis
- Intravenous Drug Use
- Culturally Appropriate and Comprehensive Services for Special Populations
- Youth Access to Tobacco Products
- Pregnant Women and Mothers with Dependent Children
- Substance Abuse Services in the Criminal and Juvenile Justice Systems
- Adult Binge Drinking
- Prescription Drug Abuse
- Children's Mental Health
- Improve mental health and substance abuse service outcomes and quality of care.
- Mental health services in the criminal justice system
- Suicide Prevention

Mental Health Summary

The prevalence of mental health conditions in specific demographic groups in Wisconsin, estimated with national rates, indicates patterns in 2013 similar to those in the previous report when females and middle-aged individuals were most likely to have mental health needs.

This update focuses on the county mental health service system only in regards to consumers' ability to access services; the original report documented access across both the private and public sectors. The number of youth accessing the county mental health system has been steadily declining; only 4.7% of youth with any type of mental illness access county services, compared to 8.9% of adults. However, the last report also documented that many youth access Medicaid services through non-county Medicaid providers to meet their needs. The county system also plays a major role in crisis care as 43% of all episodes of care included only a single crisis intervention, an emergency room visit, or an admission to an inpatient hospital.

County mental health services are also used as a proxy for the system's workforce capacity. While the array of community mental health services is still currently expanding, the relative amount of community, crisis and inpatient services varies widely across counties indicating where gaps in service array and workforce capacity may exist. Efforts to broaden the use of certified peer specialists to expand the county's capacity have resulted in an increase from 193 to 333 peer specialists from 2012-April 2015 as well as an expansion to several new counties who did not use peer specialists in 2012.

An area of concern is the increase in Wisconsin's suicide rate in 2013 from 12.6 to 14.4 per 100,000 people. Middle-aged (45-64 years old) males continue to have the highest suicide rates.

The 30-day inpatient hospital readmission rates for consumers in the county mental health system have been added to this update and indicate a decline in Wisconsin over the last five years from 9.7% to 7.7%, although county rates vary indicating areas of the state may still have a need in preventing recurring expensive acute care. Mental health consumer satisfaction levels are updated through 2013 indicating similar results to the last report - Wisconsin's consumers are generally satisfied with their access and quality of care, but their satisfaction with the outcomes of their care remains below the national average.

Substance Abuse Summary

Adult misuse of alcoholic beverages across Wisconsin has not changed and remains above the national average. However, in 2013, Wisconsin youth who report consuming five or more drinks during an occasion of drinking in the past 30 days dropped below the national average for the first time in 10 years. The rate of youth who report having their first full drink of alcohol before age 13 is down and remains below the national average. Alcohol-related traffic crashes and fatalities continue to decline.

Unhealthy and life-threatening use of alcohol and other drugs among adults resulting in death continues to rise in Wisconsin. Largely preventable, there were 1,202 alcohol and 1,054 illicit or habit-forming drug deaths in 2013. The average age of death for these substance-related deaths is mid-50s. Opiate (heroin and narcotic pain medications) treatment admissions and deaths continue to rise and are second only to alcohol. Opiate-related deaths have risen nearly 40% in the past 5 years to 667 statewide. At the same time, Wisconsin lags behind the national average in the use of medication adjuncts in the treatment of heroin and narcotic addiction. Illicit drug use among youth remains below the national average.

Safety-net, County-authorized or subsidized, publicly-supported substance use services continue to decline at a rate of about 3 percent each year. In 2013, thirty County agencies identified services that were not available due to lack of sufficient funds such as residential or housing services, narcotic treatment, intensive outpatient counseling, case management, wrap-around services and transportation. Counties with the highest rate of uninsured persons and having a slightly higher need for publicly-supported safety-net services include Clark, Jefferson, Milwaukee, Vilas and Waupaca. Wisconsin continues to provide less residential and intensive outpatient treatment services than the national average. Successful treatment completion rates for African Americans, American Indians, females, adolescents and heroin/opiate abusing clients are below the state average of 52%.

A first ever Wisconsin statewide client satisfaction with publicly-supported substance use services survey was completed in the fall of 2014. Seventy-four percent (74%) of former clients responding to the survey reported service satisfaction. This compares favorably with national benchmark surveys. The Division of Mental Health and Substance Abuse Services is planning to facilitate two quality improvement projects for County-based providers of substance use services addressing perceived service barriers of appointment convenience and transportation assistance that were identified through the survey.

While the federal Bureau of Labor Statistics is projecting a 33% increased need for substance abuse professionals by the year 2016, Wisconsin has recently gained only 1% in its substance abuse professional workforce.

List of Tables

Table 1: Prevalence Rates of Mental Illness, United States and Wisconsin, 2012-2013.....	8
Table 2: New Cases of Tuberculosis Per 100,000 Population, Wisconsin and United States, 2013.....	15
Table 3: Utilization of County Mental Health Services, by County/Region, 2013.....	17
Table 4: Substance Abuse Prevalence in United States, 2009-2010, and Substance Abuse Clients Served in Wisconsin, 2013.....	22
Table 5: Count of Consumers Receiving Mental Health Services, by Service Category, Wisconsin, 2012 & 2013.....	23
Table 6: Count of Consumers Receiving Mental Health Services, by Service Category and County/Region, Wisconsin, 2012.....	24
Table 7: Count of Consumers Receiving Mental Health Services, by Service Category and County/Region, Wisconsin, 2013.....	25
Table 8: Mental Health Service Categories, with Grouped SPC Service Codes.....	26
Table 9: Count of Individuals on CSP Waitlists, by County/Region, 2013.....	27
Table 10: Count of Consumers Receiving Substance Abuse Services, by Service Category, Wisconsin, 2012 & 2013.....	30
Table 11: Count of Consumers Receiving Substance Abuse Services, by Service Category and County/Region, Wisconsin, 2012.....	31
Table 12: Count of Consumers Receiving Substance Abuse Services, by Service Category and County/Region, Wisconsin, 2013.....	32
Table 13: Substance Abuse Service Categories, with Grouped SPC Service Codes.....	33
Table 14: Distribution of Substance Abuse Services Used, Wisconsin 2013 and United States 2012.....	34
Table 15: Percent of Client Admissions that Received Medication-Assisted Treatment, Wisconsin 2013 and United States 2012.....	35
Table 16: CSP Implementation of ACT, by Implementation Step, Wisconsin, 2011-2013.....	40
Table 17: CCS Implementation of Various EBPs, by Implementation Step, Wisconsin, 2011-2013.....	42
Table 18: Positive Perceptions of Mental Health Services, by Domain and Year, Adults in Wisconsin, 2003-2013.....	44
Table 19: Positive Perceptions of Mental Health Services, by Domain and Year, Caregivers of Youth in Wisconsin, 2003-2013.....	45
Table 20: Mental Health Inpatient 30-Day Readmission Rates, by County/Region, SFY 2009-2013.....	59

List of Figures

Figure 1: Adult Mental Health Prevalence Rates, by Age Group, 2012-2013.....	9
Figure 2: Adult Mental Health Prevalence Rates, by Gender, 2012-2013.....	9
Figure 3: Adult Mental Health Prevalence Rates, by Race, 2012-2013.....	10
Figure 4: Heavy Occasion (Binge) Alcohol Use, Adults, Wisconsin and United States, 1994-2013.....	11
Figure 5: Opiate Use in Past Year, Adults, Wisconsin and United States, 2004-2013.....	12
Figure 6: Number of Persons Admitted to Drug Abuse Treatment, For Selected Illicit Drugs, Wisconsin, 2005-2013.....	12
Figure 7: Marijuana Use in Past 30 Days, Youth, Wisconsin and United States, 1993-2013.....	13
Figure 8: Heavy Occasion (Binge) Alcohol Use, Youth, Wisconsin and United States, 1993-2013.....	14
Figure 9: Number of Persons Receiving County Mental Health Services, Adults and Youth, Wisconsin, 2000-2013.....	16
Figure 10: Percent of Persons Citing Each Reason for Not Receiving Mental Health Treatment, United States, 2013.....	20
Figure 11: Number of Persons Receiving Substance Abuse Services, Adults and Youth, Wisconsin, 2000-2013.....	21
Figure 12: Wisconsin Certified Peer Specialists, by County, as of April 2015.....	29
Figure 13: Number of Detox Persons and Admissions, Wisconsin, 2005-2013.....	35
Figure 14: Substance Abuse Treatment Workforce in Wisconsin, 2007-2013.....	36
Figure 15: Percent of CSP Programs Offering Various EBPs, Wisconsin, 2011-2013.....	38
Figure 16: Percent of CSP Consumers Served with EBPs, Wisconsin, 2011-2013.....	39
Figure 17: Percent of CCS Programs Offering Various EBPs, Wisconsin, 2011-2013.....	40
Figure 18: Percent of CCS Consumers Served with EBPs, Wisconsin, 2011-2013.....	41
Figure 19: Positive Perceptions of Mental Health Services, by Domain and Year, Adults in Wisconsin, 2003-2013.....	43
Figure 20: Positive Perceptions of Mental Health Services, by Domain and Year, Caregivers of Youth in Wisconsin, 2003-2013.....	45
Figure 21: Substance Abuse Service Completion Among Survey Respondents and All Service Recipients, Wisconsin, 2014.....	46
Figure 22: Count of Respondents, by How Services Could be Made Better, Wisconsin, 2014.....	48
Figure 23: Substance Abuse Outpatient Treatment Completion Rates, Wisconsin & U.S. Average, 1993-2013.....	49
Figure 24: Substance Abuse Outpatient Treatment Completion Rates, Among Various Population Groups, Wisconsin, 2013.....	50
Figure 25: High School Students Reporting Driving After Drinking Alcohol, In the Past 30 Days, Wisconsin and United States, 1993-2013.....	51
Figure 26: First Use of Alcohol Prior to Age 13, Wisconsin and United States, 1993-2013.....	52
Figure 27: Number of Alcohol-Related Hospitalizations, Wisconsin, 1990-2012.....	53
Figure 28: Alcohol and Mood-Altering Drug Deaths, Wisconsin, 1970-2013.....	54
Figure 29: Number of Mood-Altering Drug Deaths, by Type of Drug, Wisconsin, 1982-2013.....	55
Figure 30: Alcohol-Related Traffic Crashes and Fatalities, Wisconsin, 1983-2013.....	56
Figure 31: Wisconsin and U.S. Suicide Rates 2000-2013.....	57
Figure 32: Suicide Rates for Wisconsin Demographic Groups, 2013.....	58

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 2015-2016 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. With the many healthcare reforms in the Federal Patient Protection and Affordable Care Act, Federal guidance requests that the needs assessment address issues related to the changing healthcare environment and the impact on uninsured persons.

Needs Assessment Update

This report is an update of the Wisconsin Mental Health and Substance Abuse Needs Assessment completed and published in February, 2014. The 2014 report contained data through 2010 on most indicators presented. For this 2015 update, selected needs assessment data and analyses are refreshed through calendar year 2013 (most recent year available) to inform planners and policy makers in their determination of mental health and substance abuse priorities and programs. Data updates are organized in the following sections:

- Populations Affected or Prevalence
- Access to Services
- Service and Workforce Capacity
- Service Outcomes or Effectiveness

The updated data and information come from a variety of secondary sources including the United State Census Bureau, National Survey on Drug Use and Health, National Centers for Disease Control and Prevention, Wisconsin Program Participation System, Wisconsin Crime Information Bureau, Wisconsin Department of Transportation, and many others. The specific sources are noted with each figure, chart or table presented.

I. Prevalence

Mental Health Prevalence

Prevalence rates of mental health for large populations typically change gradually over 1-2 year periods. The original “Wisconsin Mental Health and Substance Abuse Needs Assessment” included data for a 2010-2011 combined period. The updated mental health prevalence rates for the United States and Wisconsin are described below for 2012-2013, the most recent period available at the time of this update. The national and state mental health prevalence estimates have fluctuated just one percentage point or less. The rates for a few smaller demographic groups have changed slightly more.

Two types of mental health prevalence rates are described. 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). A second group of individuals with more mild mental health conditions experience symptoms but are still 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 most recent estimates indicate an overall national prevalence of AMI at 18.5% and of SMI at 4.1% for adults 18 and older. Wisconsin’s specific overall adult rates of AMI and SMI are estimated to be very similar at 18.3% and 4.2% respectively. For children, the same national prevalence estimate of children’s mental health from the initial Needs Assessment is still relevant. The rates of AMI and SED are significantly higher for children.

Table 1: Prevalence Rates of Mental Illness, United States and Wisconsin, 2012-2013

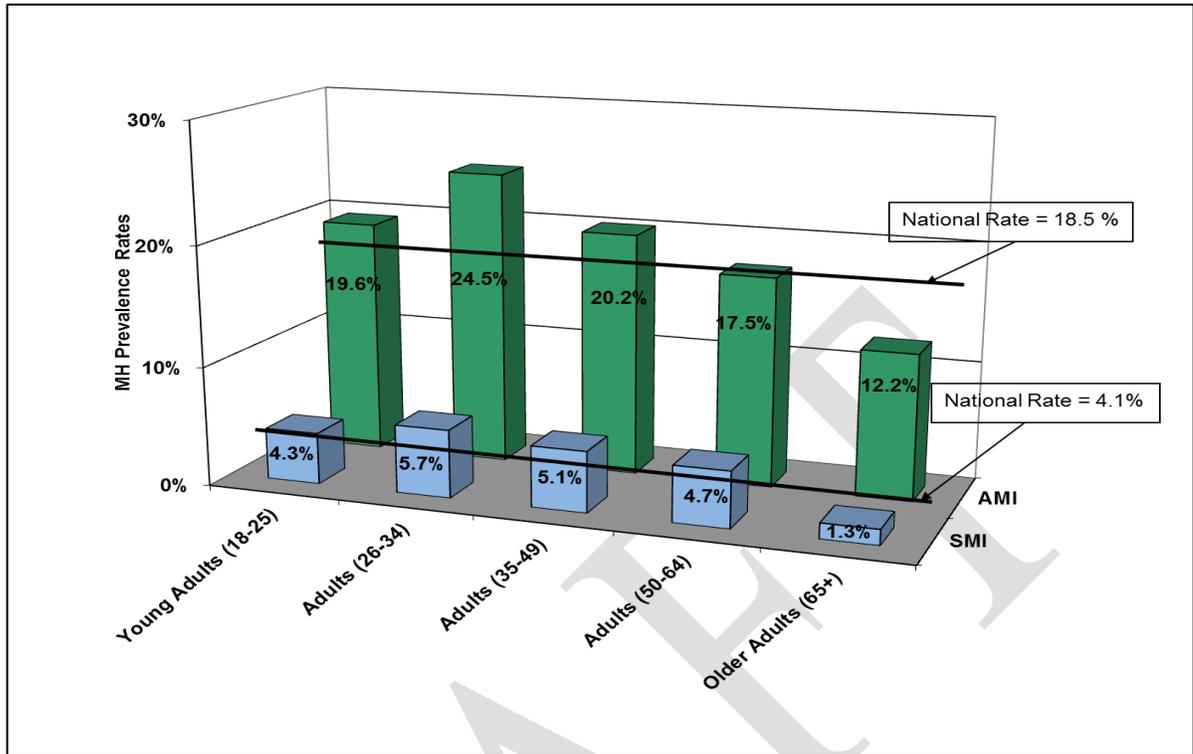
	Any Mental Illness (AMI)	Serious Mental Illness (SMI/SED)
ADULTS (National) ^a	18.6%	4.1%
ADULTS (Wisconsin) ^a	18.3%	4.2%
CHILDREN (National) ^b	21.0%	11.0%
CHILDREN (Wisconsin)	Not available	Not available

Data Sources: (a) National Survey on Drug Use and Health, 2012-2013; (b) MECA study.

Because Wisconsin mental health prevalence rates are not available for all demographic groups, national rates are described below.

Relative to the national 18.5% rate of AMI, young adults ages 26-34 have the highest rates of AMI (at 24.5%); this rate declines with each older age group, similar to the previously cited 2009 prevalence data in the original Needs Assessment report. The rate for young adults ages 18-25, however, has changed significantly from 30.0% in 2009 to 19.6% in the 2012-2013 combined period. However, prevalence estimates for smaller age groups such as this one are susceptible to larger fluctuations over time because fewer individuals are used to create the estimate. In addition, the prevalence rate methodology was improved after 2009 which also explains the large decrease in mental health prevalence for this group. Rather than a large decrease in mental health prevalence for the 18-25 age group, much of the change should be attributed to the improved estimate.

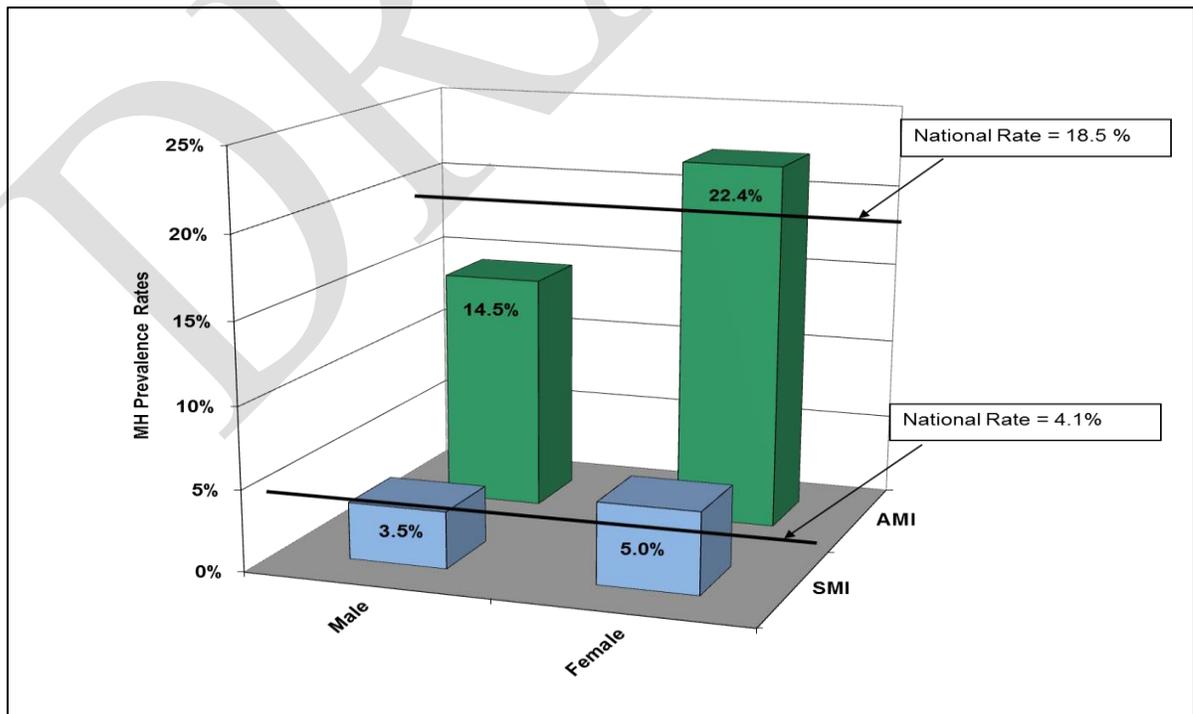
Figure 1: Adult Mental Health Prevalence Rates, by Age Group, 2012-2013



Data Source: National Survey on Drug Use and Health, 2012-13.

Females continue to have significantly higher rates of mental health needs than males.

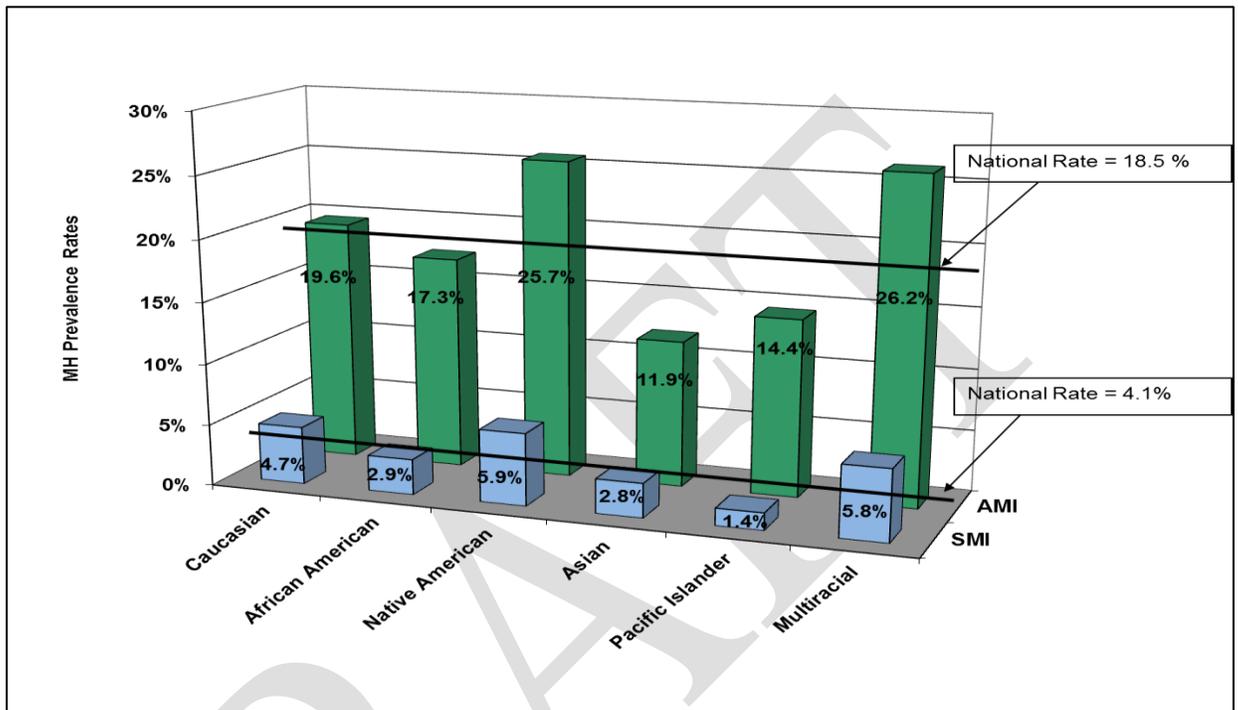
Figure 2: Adult Mental Health Prevalence Rates, by Gender, 2012-2013



Data Source: National Survey on Drug Use and Health, 2012-13.

When racial and ethnic groups are examined, Native Americans and individuals with multiracial backgrounds have the highest mental health prevalence rates; Asians and Pacific Islanders have the lowest. While rates for most groups stayed the same or decreased slightly, the rate for Native Americans increased since 2009 by approximately four percent.

Figure 3: Adult Mental Health Prevalence Rates, by Race, 2012-2013

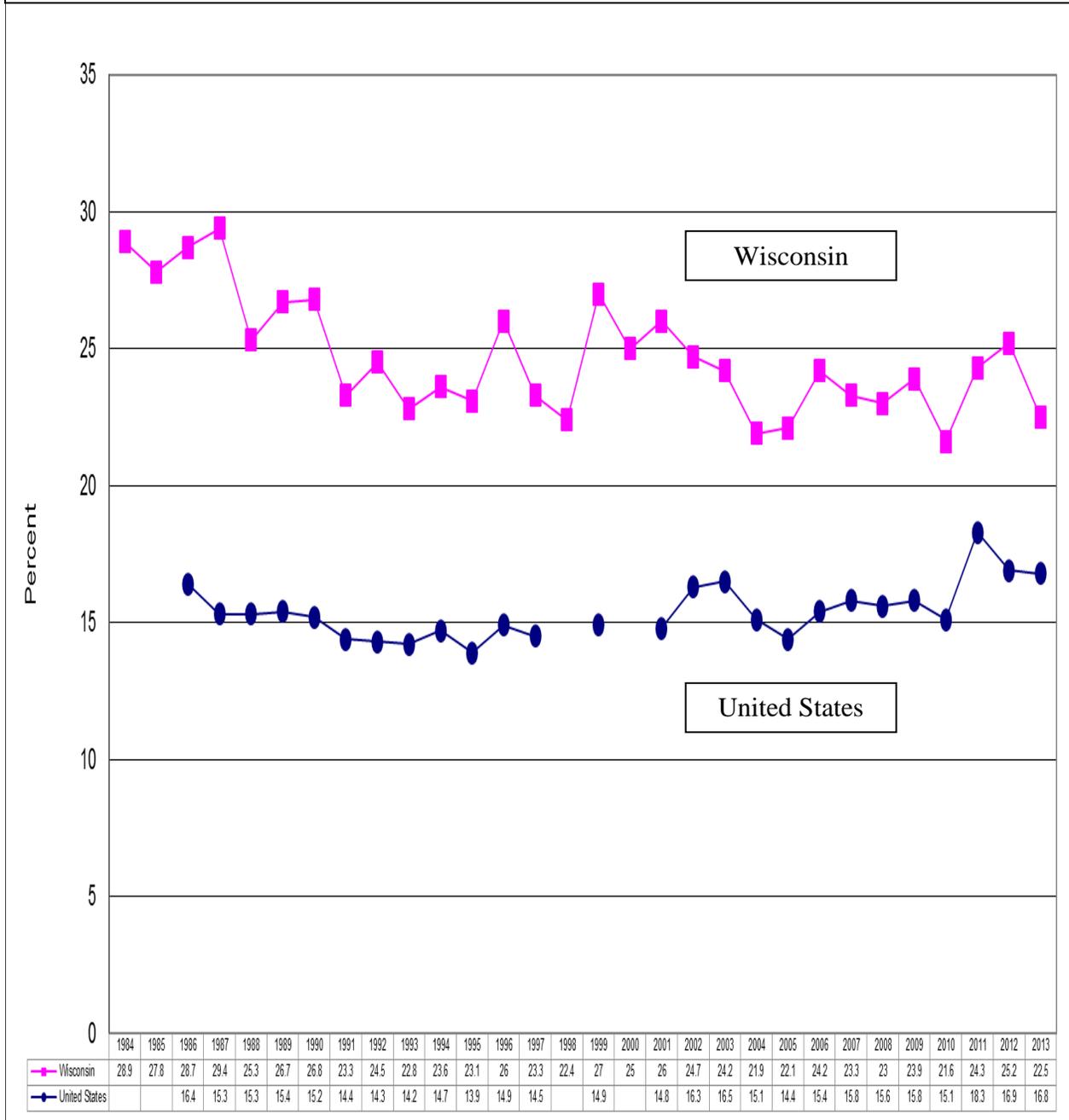


Data Source: National Survey on Drug Use and Health, 2012-13.

Substance Abuse Prevalence

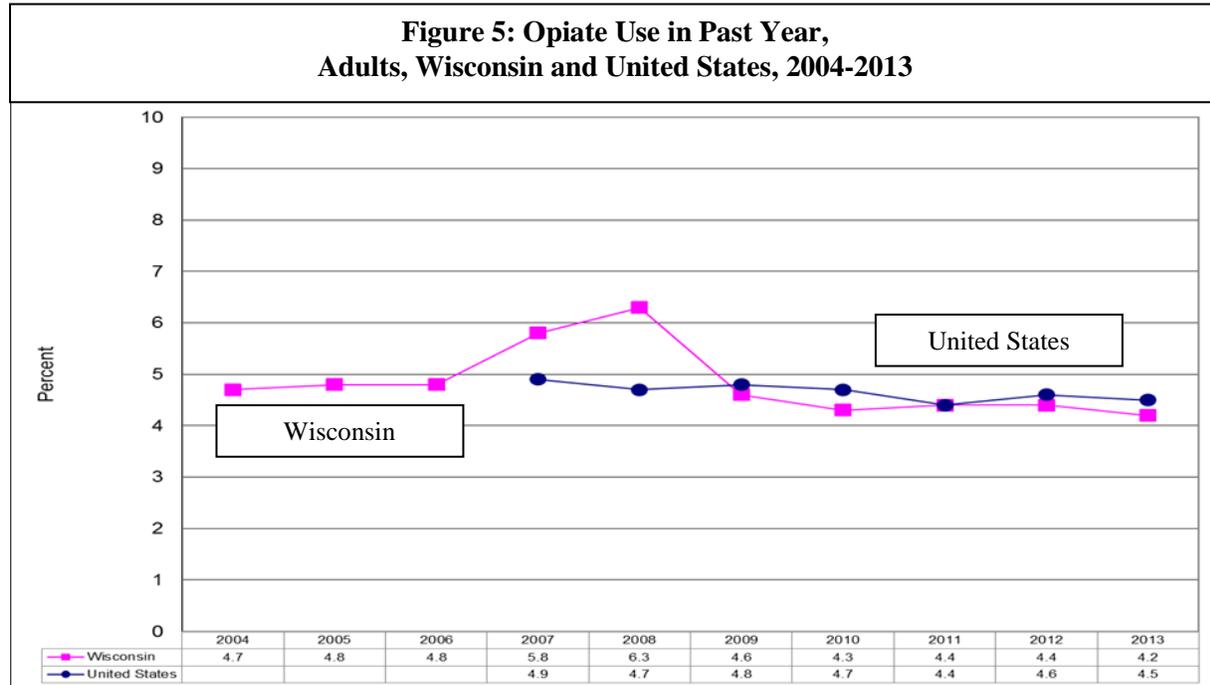
The graph below presents the percent of adults in the general population who report consuming five or more drinks during an occasion of drinking in the past 30 days. Wisconsin continues to exceed the national rate by nearly 6 percentage points.

Figure 4: Heavy Occasion (Binge) Alcohol Use, Adults, Wisconsin and United States, 1994-2013



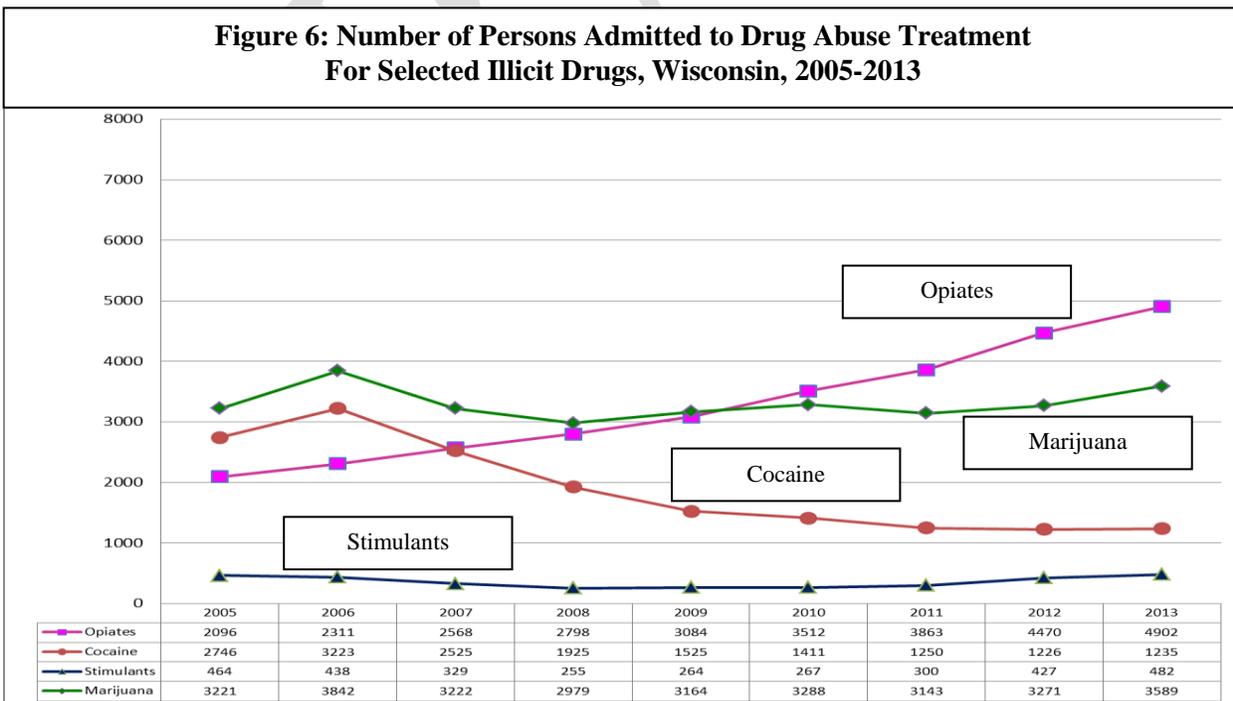
Data Source: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC)

The reported non-medical use of opiate-based medications in the past year continues at above 4% of the adult population in Wisconsin but is slightly less than the national average.



Data Source: National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Services Administration (SAMHSA)

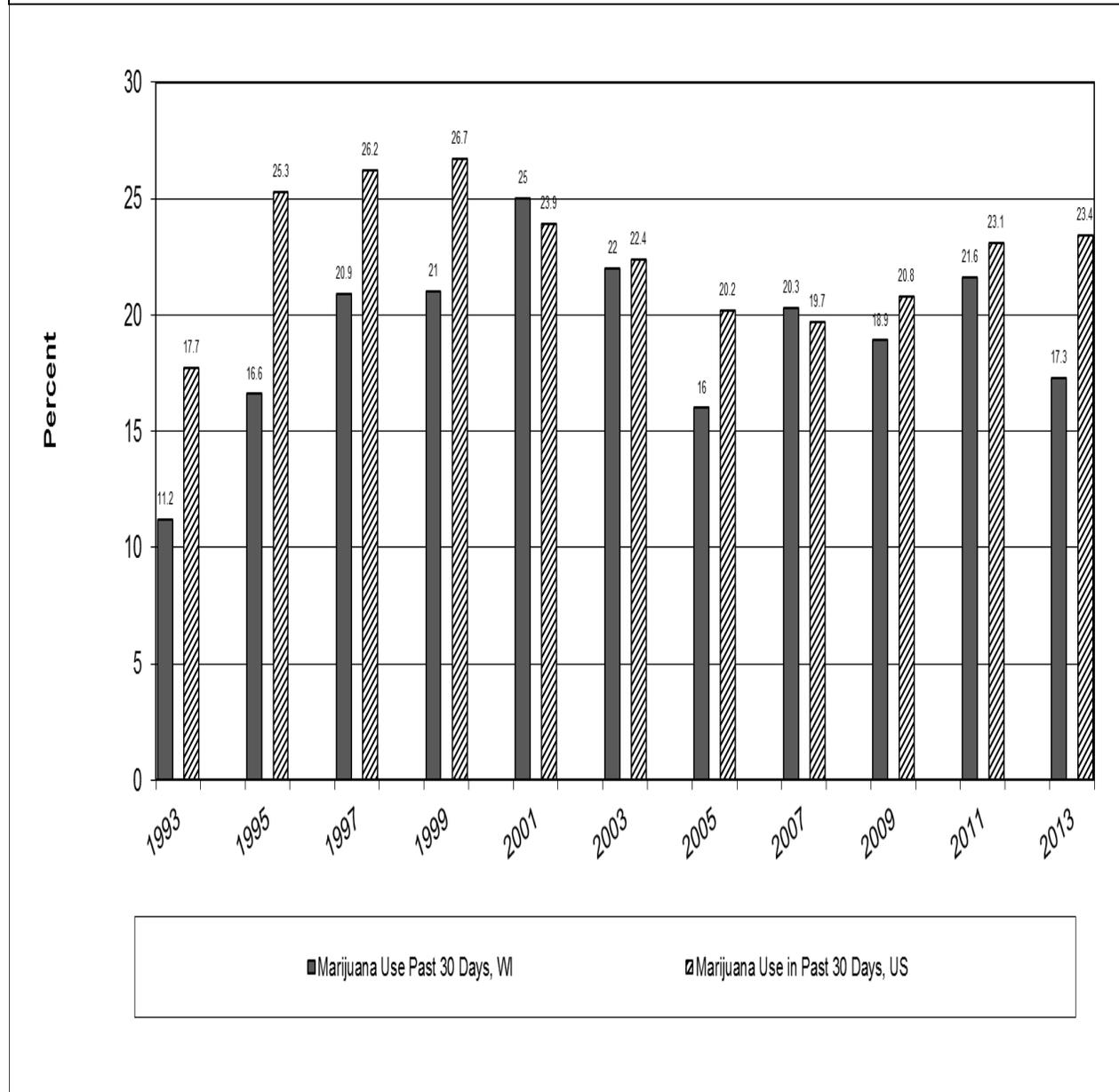
An indication of the magnitude of Wisconsin’s opiate abuse problem comes from state treatment admission data. Opiate use and addiction treatment admissions continue to increase and are much greater than admissions for other illicit drugs such as marijuana, cocaine and stimulants.



Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

Recent marijuana use among Wisconsin youth under age 18 dropped to 17%, remains lower than the national average, but continues to be higher than Wisconsin marijuana use rates from the 1990s.

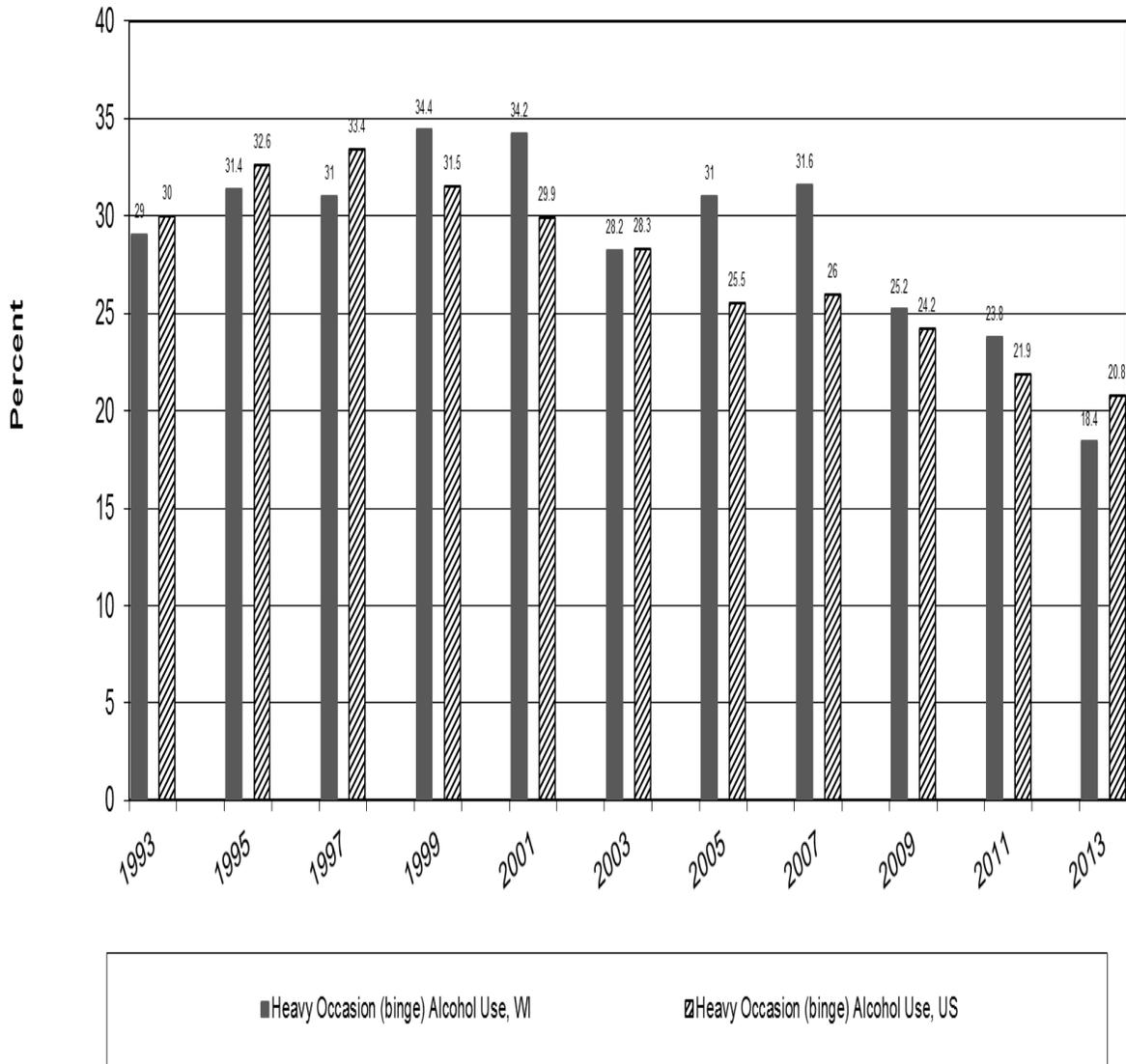
Figure 7: Marijuana Use in Past 30 Days, Youth, Wisconsin and United States, 1993-2013



Data Source: Youth Risk Behavior Survey (YRBS), Centers for Disease Control and Prevention (CDC)

The graph below presents the percent of youth who report consuming five or more drinks during an occasion of drinking in the past 30 days. In 2013, Wisconsin dropped below the national average for the first time in 10 years.

Figure 8: Heavy Occasion (Binge) Alcohol Use, Youth, Wisconsin and United States, 1993-2013



Data Source: Youth Risk Behavior Survey (YRBS), Centers for Disease Control and Prevention (CDC)

New cases of tuberculosis in Wisconsin remain low in comparison to the national average: Wisconsin saw less than 1 new case of tuberculosis for every 100,000 people in the state, while the rate of new cases across the total US was over three times as high.

Table 2: New Cases of Tuberculosis Per 100,000 Population, Wisconsin and United States, 2013	Wisconsin	United States
	0.9 new cases	3.0 new cases

Data Source: Centers for Disease Control and Prevention (CDC)

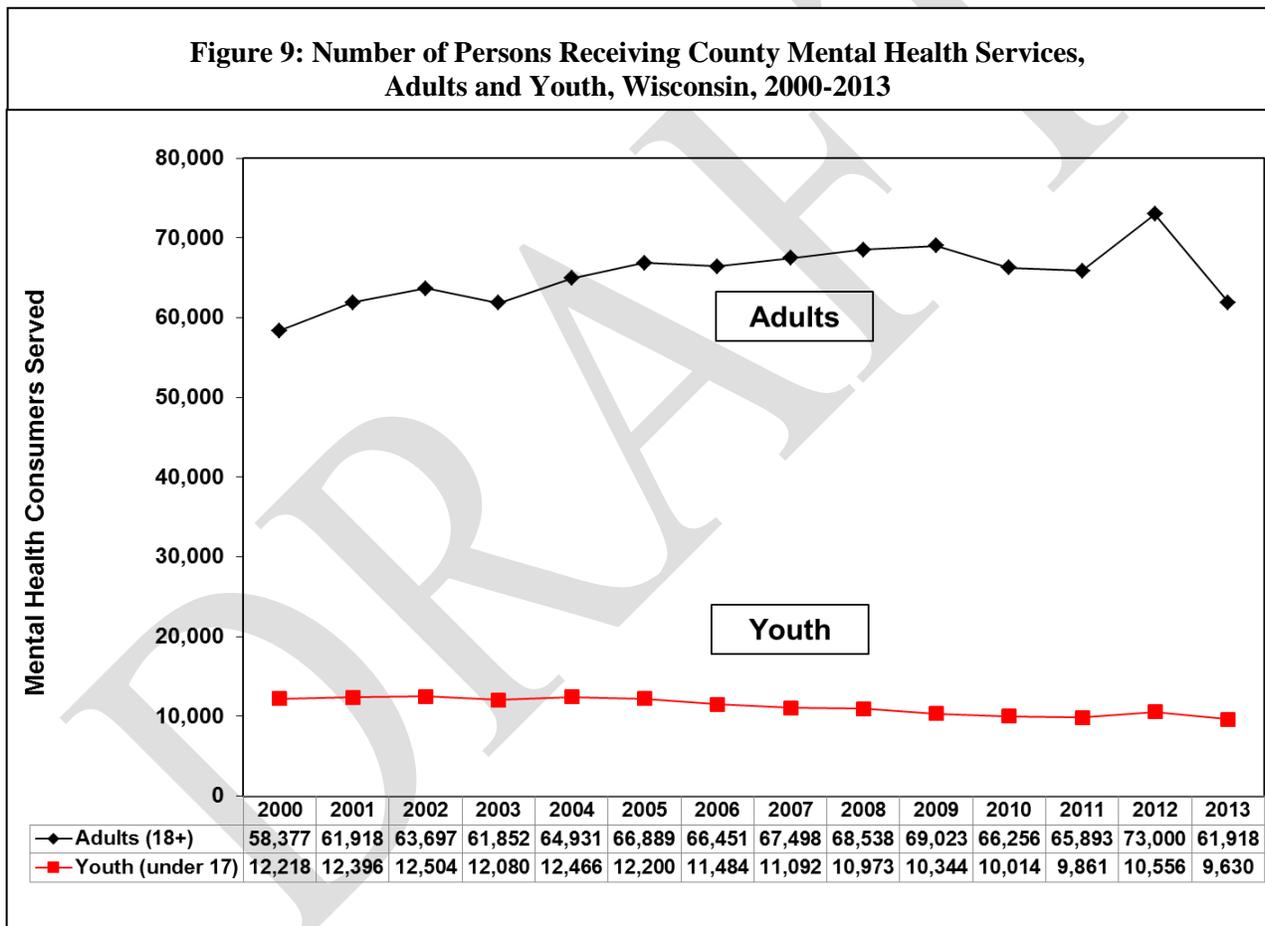
DRAFT

II. Access to Services

Number of Mental Health Consumers Served

Issues with initially accessing mental health services and maintaining adequate access to services are both updated in this section. Figure X describes the number of individuals who were able to access the county public mental health services system in the last 14 years.

The total number of individuals served through the county public mental health service system has remained fairly consistent overall in the range of approximately 74,000-79,000 during the 2000-2013 time period. The fewest individuals (70,595) were served in 2000 and the second lowest number of individuals (71,548) were served in 2013.



Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

The numbers of adults and children who have accessed the county mental health system has been less consistent over time. Except for the unexplained decline in 2013, the number of adults has increased by 6% and the number of children has gradually declined by 21% over the 2000-2013 period. While these are consistent trends, the fluctuations in the adults served in 2012 and 2013 illustrated in the figure below may have to wait for 2014-15 data to determine if it is a trend. A change in the State Department of Health Services data system for counties occurred in the 2012-13 period which may account for some of the unusual increase and decrease in this period.

Geographic Disparities in Access to Mental Health Treatment

For each county in 2013, the table below displays the estimated number of adults and youth with any mental illness (AMI), the number of mental health consumers served through the county system, and the percentage of individuals with an AMI who accessed the county system for services. Although the prevalence of individuals with AMI (18.3% among adults and 21.0% among youth) has changed only slightly, this update includes only the county mental health consumers who were served and does not include all Medicaid recipients or individuals served through other sectors as the original Needs Assessment report did.

The original report revealed that 42% of youth with AMI accessed services using any type of public funding compared to just 28% of adults. Table 3 below illustrates that the opposite is true in the county mental health system where a higher percentage of adults (8.9%) are able to access services compared to youth (4.7%). Youth are more likely to access Medicaid services outside of the county system. However, the greater variation in the access rates for youth compared to adults across different counties indicates youth access to services could be improved. Less than two percent of youth with AMI accessed mental health services in 21 counties while only 2 counties had a rate of two percent or less for adults.

Table 3. Utilization of County Mental Health Services, by County/Region, 2013

County	Estimated Number of Adults w/AMI	Number of Adults Served	Percent of Adults w/AMI	Estimated Number of Youth w/AMI	Number of Youth Served	Percent of Youth w/AMI
Adams	3,178	661	20.8%	532	160	30.1%
Ashland	2,275	170	7.5%	567	10	1.8%
Barron	6,559	723	11.0%	1,542	106	6.9%
Bayfield	2,243	91	4.1%	455	17	3.7%
Brown	34,655	4,234	12.2%	9,399	422	4.5%
Buffalo	1,941	25	1.3%	460	3	0.7%
Burnett	2,290	260	11.4%	469	32	6.8%
Calumet	6,650	629	9.5%	2,061	139	6.7%
Chippewa	8,820	567	6.4%	2,224	82	3.7%
Clark	4,515	719	15.9%	1,520	156	10.3%
Columbia	8,028	709	8.8%	2,048	121	5.9%
Crawford	2,386	429	18.0%	579	68	11.7%
Dane	71,392	3,100	4.3%	15,918	438	2.8%
Dodge	12,705	1,183	9.3%	3,021	235	7.8%
Door	4,178	256	6.1%	783	9	1.1%
Douglas	6,353	224	3.5%	1,430	22	1.5%
Dunn	6,428	620	9.6%	1,373	21	1.5%
Eau Claire	14,507	846	5.8%	3,121	100	3.2%
Florence	674	62	9.2%	122	11	9.0%
Fond du Lac	14,483	2,468	17.0%	3,554	479	13.5%
Forest/Oneida/Vilas	9,938	1,393	14.0%	1,909	186	9.7%
Grant/Iowa	10,687	1,073	10.0%	2,510	173	6.9%
Green	5,140	504	9.8%	1,374	66	4.8%
Green Lake	2,703	563	20.8%	680	132	19.4%

County	Estimated Number of Adults w/AMI	Number of Adults Served	Percent of Adults w/AMI	Estimated Number of Youth w/AMI	Number of Youth Served	Percent of Youth w/AMI
Iron	901	195	21.7%	158	54	34.2%
Jackson	2,916	103	3.5%	706	0	0.0%
Jefferson	11,754	1,167	9.9%	3,071	113	3.7%
Juneau	3,861	620	16.1%	873	59	6.8%
Kenosha	22,856	1,533	6.7%	6,632	48	0.7%
Kewaunee	2,900	64	2.2%	757	5	0.7%
La Crosse	16,718	1,384	8.3%	3,665	195	5.3%
Lafayette	2,298	342	14.9%	659	80	12.1%
Lincoln/Langlade/Marathon	25,628	3,714	14.5%	6,640	566	8.5%
Manitowoc	11,571	525	4.5%	2,801	53	1.9%
Marinette	6,111	1,126	18.4%	1,324	325	24.6%
Marquette	2,264	647	28.6%	486	134	27.6%
Menominee	531	184	34.6%	206	63	30.6%
Milwaukee	130,889	8,647	6.6%	34,969	539	1.5%
Monroe	6,118	551	9.0%	1,764	51	2.9%
Oconto	5,351	675	12.6%	1,297	130	10.0%
Outagamie	24,525	2,433	9.9%	6,800	259	3.8%
Ozaukee	12,210	511	4.2%	3,241	7	0.2%
Pepin	1,046	15	1.4%	259	0	0.0%
Pierce	5,850	399	6.8%	1,380	42	3.0%
Polk	6,188	824	13.3%	1,600	175	10.9%
Portage	10,210	807	7.9%	2,192	59	2.7%
Price	2,084	133	6.4%	426	18	4.2%
Racine	26,985	2,159	8.0%	7,414	134	1.8%
Richland	2,532	505	19.9%	632	87	13.8%
Rock	22,110	1,715	7.8%	6,110	254	4.2%
Rusk	2,086	130	6.2%	506	9	1.8%
St. Croix	11,370	1,186	10.4%	3,537	243	6.9%
Sauk	8,705	1,192	13.7%	2,270	159	7.0%
Sawyer	2,412	121	5.0%	517	3	0.6%
Shawano	5,948	1,017	17.1%	1,463	268	18.3%
Sheboygan	16,111	821	5.1%	4,230	53	1.3%
Taylor	2,864	163	5.7%	768	8	1.0%
Trempealeau	4,035	138	3.4%	1,057	7	0.7%
Vernon	4,051	228	5.6%	1,199	22	1.8%
Walworth	14,520	1,838	12.7%	3,690	150	4.1%
Washburn	2,335	119	5.1%	488	4	0.8%
Washington	18,409	3,005	16.3%	5,034	682	13.5%
Waukesha	54,701	1,959	3.6%	14,940	207	1.4%
Waupaca	7,506	766	10.2%	1,836	91	5.0%
Waushara	3,620	753	20.8%	761	272	35.7%
Winnebago	24,131	4,117	17.1%	5,459	538	9.9%
Wood	10,620	1,520	14.3%	2,573	278	10.8%
State total	802,557	71,570	8.9%	204,041	9,632	4.7%

Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

Access to Crisis Services through the County System

While Wisconsin's county mental health system serves as an access point for many outpatient and psychosocial rehabilitation services, consumers primarily access the system in a crisis. Human Services Reporting System 2012 data reported by counties to the State DHS revealed that 50% of all episodes of care began with a crisis intervention, an emergency room visit, or an admission to an inpatient hospital. In addition:

- 43% of all episodes of care included only a single crisis intervention, an emergency room visit, or an admission to an inpatient hospital;
- 75% of consumers who began their county episode of care with a crisis intervention service received three or fewer total services.

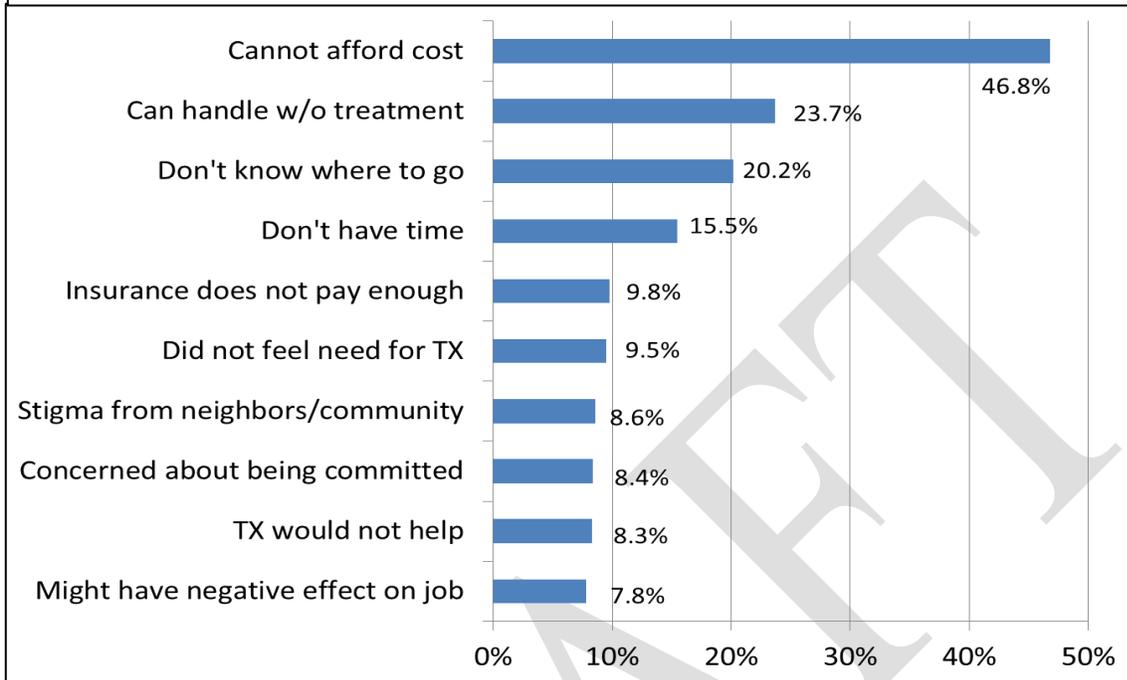
While a large percentage of individuals are accessing the county system for crisis services, many of them are not immediately accessing other community-based services after discharge from crisis services.

Barriers to Accessing Mental Health Treatment – the Consumer Perspective

A 2013 National Survey on Drug Use and Health (NSDUH) survey estimate indicated a high proportion of adults with AMI (56.1%) or SMI (31.6%) did not receive any mental health services. The NSDUH survey also asks about whether individuals had a mental health need, if they received treatment, and if they experienced barriers to accessing treatment.

In 2013, respondents who had an unmet mental health need for treatment cited the top 10 reasons for why they did not access treatment (shown in the chart below, multiple answers could be given). Cost was cited as the number one reason by 46.8% of respondents, far and above any other reason for not receiving treatment. Just under 24% of people indicated they could handle their problems without treatment and another 9.5% 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 8% of persons indicated at least one of two reasons related to stigma, including the risk of feeling stigma in the community or at work. These results were very similar to the 2011 NSDUH survey results in the original Needs Assessment report.

Figure 10: Percent of Persons Citing Each Reason for Not Receiving Mental Health Treatment, United States, 2013

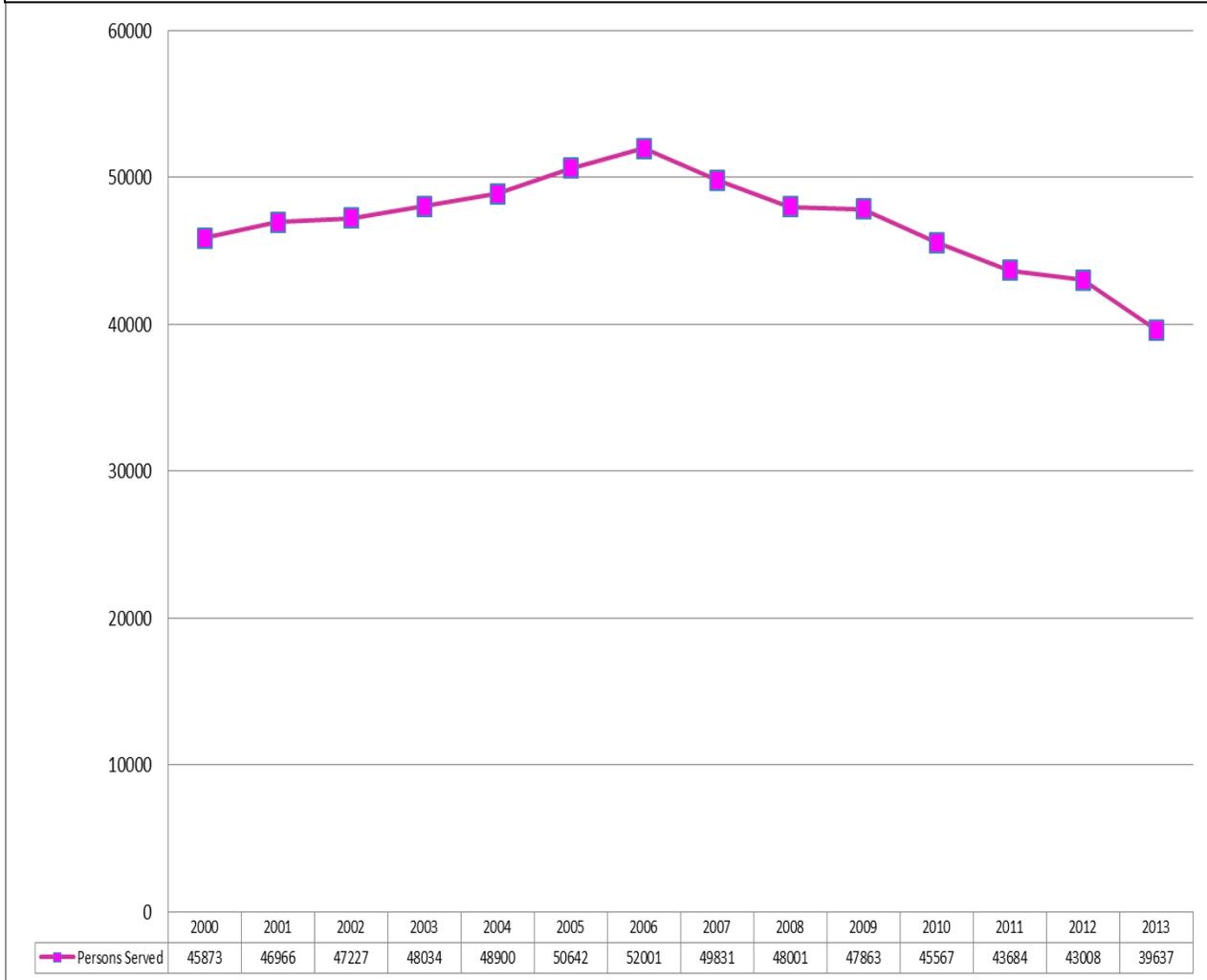


Data Source: National Survey on Drug Use and Health, 2012-13.

Substance Abuse Consumers Services and Gaps

Persons receiving County-authorized or subsidized substance use services continues to decline at a rate of about 3 percent each year. National survey data, Wisconsin sample, show that the prevalence of substance abuse is declining at a rate of about one-half of a percentage point each year. This coupled with rising health insurance coverage, tighter local government budgets and general service access issues are contributing to the decline in persons receiving publically-supported substance use services. However, as was presented in the 2014 Needs Assessment report referenced previously, just 23% of persons needing substance use services receive services.

Figure 11: Number of Persons Receiving Substance Abuse Services, Wisconsin, 2000-2013



Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

Disparities in Substance Abuse Treatment

Data on the proportion of services received by population groups can shed light on whether certain population groups have access to services or are underserved. Caucasian males, people living in urban areas, and those having an alcohol use disorder generally make up a large percentage of persons receiving substance use services. The table that follows describes the relative distribution of services provided to selected population groups (by gender, age, race and ethnicity) compared to their substance abuse prevalence. Females, youth under 18 years, persons age 65 and over, and Whites are underserved relative to their substance abuse prevalence. For example, 33% of people with a substance abuse disorder across the United States are female, but only 29% of substance abuse clients served in Wisconsin are female.

Table 4: Substance Abuse Prevalence in United States, 2009-2010, and Substance Abuse Clients Served in Wisconsin, 2013				
	Substance Abuse Prevalence, 2009-2010 Combined, NSDUH		Substance Abuse Clients Served, 2013, HSRS & PPS	
	Number	Percent	Number	Percent
Female	149,674	33%	11,389	29%
Male	<u>298,326</u>	<u>67%</u>	<u>28,248</u>	<u>71%</u>
Total	448,000	100%	39,637	100%
Age under 18	39,986	9%	1,039	3%
Age 18-64	394,800	88%	38,126	96%
Age 65 and over	<u>13,214</u>	<u>3%</u>	<u>472</u>	<u>1%</u>
Total	448,000	100%	39,637	100%
White	387,896	87%	31,278	79%
Black	25,282	6%	4,531	11%
Hispanic	25,079	6%	2,265	6%
Native American	6,075	1%	1,207	3%
Asian	<u>3,668</u>	<u><1%</u>	<u>356</u>	<u>1%</u>
Total	448,000	100%	39,637	100%

Data Source: National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Services Administration (SAMHSA); Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services.

Substance Abuse Treatment – the Consumer Perspective

One of the principal reasons persons with substance use problems do not obtain treatment is that they are unemployed and without health insurance. The Wisconsin Division of Public Health conducts its own annual Family Health Survey from a representative sample of Wisconsin residents. The latest available survey results (from 2012) confirm that 89% of Wisconsin residents have health insurance the entire year. Another 5% have health insurance for part of the year, and 6% are uninsured all year. The counties with the highest rate of uninsured persons were Clark (14%), Jefferson (13%), Vilas (13%), Waupaca (11%) and Milwaukee (10%).

III. Service and Workforce Capacity

County Mental Health Services

An assessment of the actual mental health workforce capacity across the entire state in terms of number of mental health staff and their training and expertise is not conducted regularly. As a proxy, the number of consumers receiving county mental health services and the types of services they receive is used to indicate how county mental health service systems use their resources to meet the consumers' needs. The following tables from the 2015 County Mental Health Services report produced by the Wisconsin DHS show the count of consumers who received mental health services by service category in each Wisconsin county/region, during CYs 2012 and 2013, respectively. A blank cell indicates that no consumers were reported to have received services in that category. Because individual consumers may have received more than one type of mental health service, consumers are duplicated across the service categories.

In Table X below in 2013, the county mental health system provided crisis intervention services to 18,951 consumers, or 31.1% of all consumers. The county system also provided emergency detentions, inpatient hospitalization, and residential treatment to 7.6%, 4.1%, and 3.2% respectively. Comparatively, the county system provided case management to 15.9%, Community Support Program services to 11.0%, and Comprehensive Community Services to 2.9%. This may reflect the capacity and emphasis of the Wisconsin public mental health service system to serve consumers with high-level intensive needs often requiring crisis and inpatient care. It may also indicate an underutilization of intensive community care, although such programs have expanded after 2013.

Table 5: Count of Consumers Receiving Mental Health Services, by Service Category, Wisconsin, 2012 & 2013

Mental Health Service Category	Count of Consumers	
	2012	2013
Community Support Program (CSP)	7,148	6,683
Comprehensive Community Services (CCS)	1,661	1,791
Community Recovery Services (CRS)	166	227
Coordinated Service Teams (CST)	763	883
Crisis Intervention / Emergency Outpatient	23,001	18,951
Emergency Detention (ED)	4,115	4,643
Inpatient Services	4,397	2,497
Residential Services	2,272	1,939
Partial Day Services	449	332
Court Services	868	1,026
Medication Management	17,986	15,981
Intake Assessment	4,411	4,531
Case Management	10,634	9,707
Outpatient Services	25,486	27,093
Supportive Services	1,963	1,800
Other Services	121	58

**Table 6: Count of Consumers Receiving Mental Health Services,
by Service Category and County/Region, Wisconsin, 2012**

2012 County/Region	Community Support Program (CSP)	Comprehensive Community Services (CCS)	Community Recovery Services (CRS)	Coordinated Services Teams (CST)	Crisis Intervention / Emergency Outpatient	Emergency Detention (ED)	Inpatient Services	Residential Services	Partial Day Services	Court Services	Medication Management	Intake Assessment	Case Management	Outpatient Services	Supportive Services	Other Services
Statewide	7,148	1,661	166	763	23,001	4,115	4,397	2,272	449	868	17,986	4,411	10,634	25,486	1,963	121
Adams		<25				55	<25	<25			284		<25	322		
Ashland	67			<25	46	<25		43			66	<25	<25	<25		<25
Barron	61			<25	527	41	<25	54		37	109	114	82	68	27	<25
Bayfield	38		<25		<25	<25	31	<25	<25	<25	<25	37	42	<25	<25	<25
Brown	84	92			1134	251	356	55		<25	190		323	109	59	<25
Buffalo	<25			<25		<25	<25	<25	<25		<25		<25	<25	<25	
Burnett	26				205	<25	<25				36		25	57	<25	
Calumet	37	47				<25	38	<25		101	230		448	379	38	<25
Chippewa	44		<25	<25	551	<25	<25	28					<25	<25	<25	<25
Clark	35			28		<25	32	<25			297		<25	312	<25	
Columbia	68	<25		<25	422	82	49	<25		<25	41	<25	223	111	<25	<25
Crawford	25				48	<25	<25	<25		34	259	127	40	194	<25	<25
Dane	536		39		1062		111	264	174	241		34	1246	715	620	
Dodge	71	32			135	<25	87	45			417	322	640	829	<25	
Door	62			35		<25	<25				248	37	242	172		
Douglas	100				<25	<25	<25	27		<25	<25	109	75	<25	<25	<25
Dunn	36			<25	<25	<25	<25	<25		<25	397	37	39	304	<25	<25
Eau Claire	160			112	<25	<25	<25	61			349		362	36	69	<25
Florence						<25					<25			47		
Fond du Lac	124	<25		41	309	182	110	31	28		1609			1397		
Forest/Oneida/Vilas	40	26			730	273	34	44	<25		580		321	251	<25	
Grant/Iowa	45			<25	<25	105	<25	<25	<25	<25			25	936	<25	<25
Green	68	35		<25	<25	52	<25				226			246		
Green Lake	<25	<25			124	<25	25	<25			204	<25	<25	163		
Iron	28					<25	<25				<25		67	133	<25	
Jackson	<25	<25				<25	<25	<25			<25		<25	41	<25	<25
Jefferson	156	84	<25		556	40	<25	109			651		362	514	27	
Juneau	72		<25	<25	183		<25				222		48	323		
Kenosha	171	77		52	385		55	41			501	106	<25	339	58	
Kewaunee	<25	<25		<25	79	<25	<25		<25	<25	147	65	127	71	<25	
La Crosse	119	144	<25		976		47	<25	<25		<25		<25	393	<25	
Lafayette	54				66	<25	<25	<25		<25	183	<25	<25	157	<25	<25
Lang/Linc/Marathon	257	247			614	589	160	196		<25	1397	1095	68	1317		
Manitowoc	55	<25			<25		74	55			331			382		
Marinette	94	25		<25		<25	37		29		424	<25	54	843		
Marquette	30	<25	<25	<25	140	<25	<25	<25		<25	26		57	410	37	<25
Menominee	<25		<25	<25	49	25	<25	<25			94	52	28	41		
Milwaukee	2422				6372	1352	587	152	52		673		288	2174	<25	
Monroe	37				308		37	<25	<25	<25	159	72	45	146	64	
Oconto	<25			<25	251	<25	36	<25			233			256		
Outagamie	118	155			977	36	287	70		<25	1038	<25	287	1101	239	<25
Ozaukee				<25							26	<25	<25	<25		
Pepin	<25					<25	<25	<25			<25		<25	<25		
Pierce						<25	<25	<25			186		42	261		
Polk	33				<25	<25	<25	40		<25	466	199	104	324	<25	<25
Portage		41	<25	26	45	26	74	30		<25	558		234	239	<25	
Price	52			<25	97	<25	<25	<25				<25	29	<25	<25	
Racine	128			<25	1300		200	40	76			<25	253	332	<25	
Richland		83				<25	<25				256	166		201		
Rock	292			35	781	252	69	<25			431	203	143	417		
Rusk	<25				73	<25	<25			<25	<25	<25	64	37	<25	
Sauk	182	61			398	80	39	40			428		<25	604	<25	
Sawyer	54			<25		<25		<25			55	<25		32		
Shawano	35			<25	479		94			<25			50	686	<25	
Sheboygan	122	32	<25	47	59		147	134	<25		270	65	426	599	224	25
St. Croix	99					85	<25	<25			545		56	717		
Taylor	<25				80	<25	<25	<25			97	<25	90	104	<25	<25
Trempealeau	57			<25		<25	<25	<25	<25		48	<25		39	<25	
Vernon	66			<25	<25	<25	<25	<25	<25	<25				95	<25	
Walworth	51				71	<25	<25	<25		<25	707		46	276	<25	<25
Washburn	<25			<25		<25	<25	<25			<25		37	65		
Washington	92	58	<25	<25	1422		277	116	49	122	106		30	1460	86	<25
Waukesha	152	114	31	42	61	<25	508	77	<25	244	<25	519	268	848	64	<25
Waupaca	26				334	102	<25	50			357		240	239	79	
Waushara	36	33		<25	130	33		<25			174		<25	420	<25	<25
Winnebago	122	102			1852	49	200	203	<25		1663	607	2920	1473	<25	
Wood	154	76	28			88	383	<25	<25			371		830	47	<25

Data Source: Program Participation System (PPS), WI Department of Health Services

**Table 7: Count of Consumers Receiving Mental Health Services,
by Service Category and County/Region, Wisconsin, 2013**

2013 County/Region	Community Support Program (CSP)	Comprehensive Community Services (CCS)	Community Recovery Services (CRS)	Coordinated Services Teams (CST)	Crisis Intervention / Emergency Outpatient	Emergency Detention (ED)	Inpatient Services	Residential Services	Partial Day Services	Court Services	Medication Management	Intake Assessment	Case Management	Outpatient Services	Supportive Services	Other Services
Statewide	6,683	1,791	227	883	18,951	4,643	2,497	1,939	332	1,026	15,981	4,531	9,707	27,093	1,800	58
Adams		<25				42					235	<25	<25	467	<25	
Ashland	39			<25	58	<25		50			58			<25	<25	<25
Barron	61			27	501	27	<25	62		42	105	90	87	44	<25	<25
Bayfield	33		<25		<25	<25	<25	<25		<25	<25	25	29	<25	<25	<25
Brown	76	73			1440	457	148	48		112	486		294	265	144	<25
Buffalo				<25		<25	<25				<25	<25	<25	<25	<25	
Burnett	<25				186	<25	<25	<25			40		<25	38		
Calumet	36	38				<25	48	<25		112	223		406	434	35	<25
Chippewa	38		<25	<25	525	<25	<25	<25					<25	<25		
Clark	32			<25	181	<25	29	<25			267	<25	<25	372	<25	
Columbia	66	<25		<25	472	78	28	<25		<25	65	37	94	131	<25	
Crawford	25				94		<25	<25	<25	<25	252	123	<25	173	<25	<25
Dane	488		107		974		66	183	165	182		<25	1592	617	266	
Dodge	64	31			138	56	81	49			640	295	634	403	<25	
Door	48			44							141		157	47		
Douglas					43		<25	<25				158	60		<25	
Dunn	33			<25	<25	<25	<25	<25			127	<25	51	480	<25	
Eau Claire	147			101		<25	<25	60			362		369	<25	69	<25
Florence					<25	<25	<25				26			50		
Fond du Lac	135	<25		54	291	212	109	32	28		1454		<25	1355		
Forest/Oneida/Vilas	39	<25			676	242	26	41	<25		533		344	234	<25	
Grant/Iowa	43			<25	<25	74		<25	<25				37	959	<25	<25
Green	67	28		<25		42	<25				241			253		
Green Lake	<25	<25			233		<25	<25			229	<25	<25	219		
Iron	28		<25			<25					<25		108	128		
Jackson	<25	<25			<25	<25	<25	<25			<25			40	<25	
Jefferson	156	88	<25		528	133		73			594		341	517	<25	
Juneau	74		<25		188		<25	<25			228		45	318		
Kenosha	153	88		95	497		<25	42			<25	125	<25	784	49	
Kewaunee	<25	<25		25	<25				<25	<25	<25		<25	<25	<25	
La Crosse	102	160	<25		939		38	<25			148			326		
Lafayette	42				84	<25	<25	<25			196	<25		187		
Lanc/Linc/Marathon	245	404	<25		553	653	129	172		<25	1674	1272	42	1331		
Manitowoc	55	25					123	55			238			385		
Marinette	80	73		31		<25	<25		<25		410		41	830		
Marquette	33	<25		31	222	<25	<25	<25		<25	57		48	404	40	<25
Menominee	<25				73	<25	<25	<25		<25	31	62	<25	52	<25	
Milwaukee	2435				1124	1314	<25	51	49		<25		245	1883	<25	
Monroe	32		<25		294	<25	<25	<25		<25	167	63	86	133	351	
Oconto				<25	318	<25	44				236			259		
Outagamie	99	131			976		264	161		<25	1142		236	1508	274	<25
Ozaukee	44			49										207		
Pepin	<25					<25	<25	<25			<25		<25	<25	<25	
Pierce					63	29	<25	<25			170	<25	40	245		
Polk	26				147	<25	<25	34	<25	<25	414	36	97	305	<25	<25
Portage	<25	36	<25	26	66	<25	57	25		<25	460		201	232	<25	
Price	41				81	<25	<25	<25				<25	34	<25	<25	<25
Racine	117			<25	1490	119	105	39			539		622	719	<25	
Richland		70	<25		130	<25	<25				216	195		170	<25	
Rock	268			62	1033	300	156				373	207	117	440		
Rusk	<25				58	<25	<25				<25	<25	97	<25	<25	
Sauk	164	73			400		90	<25			483		<25	689	<25	
Sawyer	56			27		<25		<25			43			<25		
Shawano	38			33	292					<25			60	526	<25	
Sheboygan	76	57	<25	38	<25	<25	31	86	<25		<25		138	375	39	
St. Croix	87			<25	<25	<25	<25	26			600		77	672		
Taylor					<25	<25	<25	<25			89	<25	87	84	<25	
Trempealeau	49			<25		<25	<25	<25		<25	41	25		32	<25	
Vernon	67			<25	38	<25	<25	28	<25		27		<25	84	29	
Walworth	<25	<25			<25					<25	131		<25	193		
Washburn	<25			<25		<25	<25	<25			<25		35	63		
Washington	85	56	<25	<25	1551		275	129	57	109		<25	32	1686	79	<25
Waukesha	174	68	30	<25	73	<25	107	57	<25	390	<25	658	282	948	79	<25
Waupaca	27				339	119	<25	53			346	<25	95	266	125	<25
Waushara	40	32		<25	173	<25	<25	<25			259	<25	<25	455	<25	<25
Winnebago	109	96			1851	40	210	147			1262	592	2251	2376		
Wood	166	76	<25	<25	<25	401	30	<25	<25			479		912	46	<25

Data Source: Program Participation System (PPS), WI Department of Health Services

The following table lists the mental health service categories (combining related SPC service codes) used in the above tables.

Table 8: Mental Health Service Categories, with Grouped SPC Service Codes		
Mental Health Service Categories	SPC Code(s)	Service(s)
Community Support Program (CSP)	509	
Comprehensive Community Services (CCS)	510, 510.10	
Community Recovery Services (CRS)	511, 511.10	
Coordinated Services Teams (CST)	NA	
Crisis Intervention or Emergency Outpatient	501, 501.10 503.2 205	Crisis Intervention Emergency Room – Hospital Setting Shelter Care
Emergency Detention	503.1	
Inpatient Services	503 703, 705 925	Inpatient Detoxification (Hospital, Social Setting) Institution for Mental Disease
Residential Services	202, 204 203 504, 506 505	Adult Family Home, Group Home Foster Home Residential Care Center, County Based Residential Facility (CBRF) DD Center / Nursing Home
Partial Day Services	704, 706	Day Treatment (medical, non-medical)
Court Services	301 303	Court Intake & Studies Juvenile Probation & Supervision
Medication Management	507.10	
Intake Assessment	603	
Case Management	604	
Outpatient Services	507 507.20, 507.50 507.3 507.4	Counseling / Therapeutic Resources Individual Counseling, Intensive In-Home Group Counseling Family or Couple Counseling
Supportive Services	104, 104.10 106 107 108 110 601, 602 605 606 615	Supportive Home Care Housing / Energy Assistance Specialized Transportation & Escort Work Related Services Daily Living Skills Training Outreach, Information/Referral Advocacy & Defense Resources Health Screening & Accessibility Supported Employment
Other Services	102 103, 103.10 112 403 406 408	Adult Day Care Respite Care Interpreter Services / Adaptive Equipment Recreation / Alternative Activities Protective Payment / Guardianship Community Prevention / Organization/Awareness

Data Source: Program Participation System (PPS), WI Department of Health Services

Status of Efforts to Increase Capacity

The State DHS allocates \$1 million dollars annually to Community Support Programs (CSPs) to help relieve these waitlists. The waitlist totals are at least a partial indicator of the size of the gap in capacity for CSPs. Approximately 31% of programs did report the use of a waitlist, and they reported 410 consumers who were on the wait list at some point in 2013. Of programs that used waitlists, the average wait was 5.1 months. The use of the CSP wait list in 2013 is very similar to its use in 2011 as described in the original Needs Assessment report indicating that CSPs have similar capacity and demand for their services on an annual basis. Capacity did not expand from 2011 to 2013.

**Table 9: Count of Persons on CSP Waitlists,
by Wisconsin County, 2013**

County	Count of Persons
Ashland	27
Bayfield	10
Clark	2
Columbia	28
Dane #1	12
Dane #2	21
Green	13
Iron	2
Jefferson	1
Kenosha	72
Lafayette	15
Monroe	16
Polk	12
Price	5
Rock #1	2
Rock #2	7
Sauk	56
Sawyer	37
Sheboygan	8
Vernon	27
Waukesha	37
Total CSP Waitlists	410

Data Source: Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. 2013 Community Support Program Survey Annual Report.

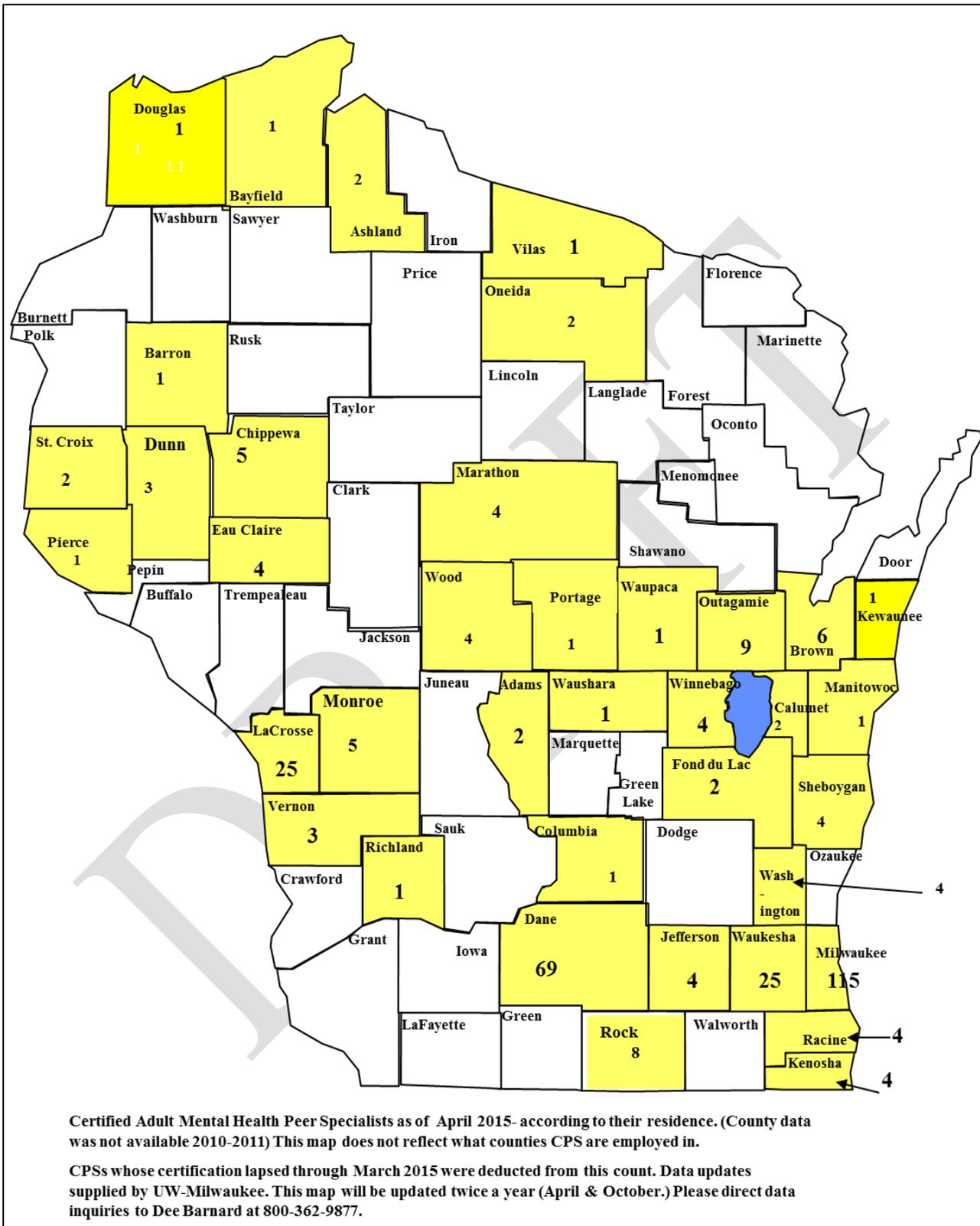
Certified Peer Specialists

The use of peer specialists to expand the capacity of the Wisconsin mental health system continues as well. The number of certified peer specialists has grown exponentially since the original Needs Assessment report. Peer specialists can not only increase the capacity of an

agency's 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. In April of 2015, there were 333 Certified Peer Specialists in Wisconsin compared to 193 in 2012. A March 2015 survey of certified peer specialists found that 66.9% of respondents were currently employed and 62.5% of the employed peer specialists had been employed for more than one year.

DRAFT

Figure 12: Wisconsin Certified Peer Specialists, by County, as of April 2015



County Substance Abuse Services

In a County Mental Health Services report to the state Legislature published in January 2015, Wisconsin's Program Participation System (PPS) data showed that 40,978 and 39,465 persons in CYs 2012 and 2013, respectively, came in contact with the publically supported substance abuse services system, a decline from the 45,560 reported in 2010.

The following table – taken from Tables 5 & 6 in the 2015 County Mental Health Services report – shows the statewide count of consumers who received substance abuse services by service category during each of the two years. [Note: Because individual consumers may have received services in more than one service category, the “total” number of consumers served cannot be calculated by adding up the count of consumers across categories (and the percent of consumers served in each category cannot be calculated by dividing each category count by that “total”).]

Table 10: Count of Consumers Receiving Substance Abuse Services, by Service Category, Wisconsin, 2012 & 2013

Substance Abuse Service Category	Count of Consumers	
	2012	2013
Community Support Program (CSP)	45	42
Comprehensive Community Services (CCS)	171	< 25
Community Recovery Services (CRS)	0	< 25
Crisis Intervention / Emergency Outpatient	367	388
Detoxification Services	5,310	4,690
Inpatient Services	57	73
Residential Services	1,940	1,896
Partial Day Services	976	860
Court Services	2,390	478
Intake Assessment	21,112	19,517
Case Management	5,100	10,281
Outpatient Services	16,252	16,606
Medication Treatment	492	514
Supportive Services	746	1,325
Other Services	< 25	191

Data Source: Program Participation System (PPS), WI Department of Health Services

The following two tables – Tables 5 and 6 in the 2015 County Mental Health Services report – show the count of consumers who received substance abuse services by service category, in each Wisconsin county/region, during CYs 2012 and 2013, respectively. Blank cells indicate where no services were reported to have been provided.

**Table 11: Count of Consumers Receiving Substance Abuse Services,
by Service Category and County/Region, Wisconsin, 2012**

2012 County/Region	Community Support Program (CSP)	Comprehensive Community Services (CCS)	Community Recovery Services (CRS)	Crisis Intervention / Emergency Outpatient	Detoxification Services	Inpatient Services	Residential Services	Partial Day Services	Court Services	Intake Assessment	Case Management	Outpatient Services	Medication Treatment	Supportive Services	Other Services
Statewide	45	171		367	5,310	57	1,940	976	2,390	21,112	5,100	16,252	492	746	<25
Adams		<25		<25			<25			118		109			
Ashland				<25	<25	<25	<25			118		79			
Barron				<25	<25	<25	25			176	<25	224		<25	<25
Bayfield					<25			<25		94	47	55	<25	<25	<25
Brown		<25			175	<25	<25			1650	<25	42	<25	36	<25
Buffalo					<25		<25			<25	<25	<25			<25
Burnett					<25		<25				42	49		<25	
Calumet					<25		<25		<25	153	45	40		<25	
Chippewa					<25		<25					54			
Clark	<25				<25	<25	<25			<25		153	<25		
Columbia		<25		<25	<25		<25		<25	388	<25	125	<25	<25	<25
Crawford				<25	<25		28			63		74		<25	<25
Dane					1261		211	136	2382	661	1581	1440		<25	
Dodge				25	54	<25	<25			645	40	276	<25	<25	
Door					<25		<25			177	<25	154			
Douglas	<25			<25	136		<25	<25		132	<25	154		<25	
Dunn					<25		73	<25		45		189	<25	<25	
Eau Claire	41				93	<25	<25				177	169		85	<25
Florence				<25			<25			<25		<25			
Fond du Lac	<25			49	151		<25			527		715			
Forest/Oneida/Vilas					56	<25	171			408	61	540		<25	
Grant/Iowa				<25	44		<25			327		351			
Green					<25					254	<25	215	<25		
Green Lake		<25		<25			<25			91		89	<25		
Iron							<25			28		36			
Jackson					<25		<25					53	<25		
Jefferson					48		<25			501	218	290	173		
Juneau					<25	<25	<25			250		151	<25		
Kenosha	<25			41	96		25			748		252	<25	<25	<25
Kewaunee				<25	<25		<25		<25	133	89	78			
La Crosse					34		<25	<25		519	231	346		62	
Lafayette				<25		<25	<25			61		60			
Lang/Linc/Marathon					172			180		1647		1105			
Manitowoc					26		41			395		<25	<25		
Marinette				<25			<25			319	<25	377		<25	
Marquette				<25	<25					94	122	127		<25	<25
Menominee				<25	<25		<25			134		118			
Milwaukee					2073		521	428				2544	217		
Monroe				<25	<25		<25			285	264	116	26	100	
Oconto				<25			<25			176		98			
Outagamie					43		125	33		100	420	153		122	
Ozaukee										385		<25		<25	
Pepin							<25	<25				<25			
Pierce				<25			<25			242		117			
Polk				<25						319		287			
Portage					49		27	<25		381	392	283		30	
Price				<25	<25	<25				60	26	27			
Racine					79	<25		35		849	65	217		<25	
Richland						<25	<25			149		132	<25	<25	
Rock					309		46			1103		533		85	
Rusk				<25	<25					47	<25	<25			
Sauk		<25		60	63		<25	<25			<25	124			
Sawyer					<25					195		198		<25	
Shawano				45	<25	<25				322		223			
Sheboygan					<25		62			352	<25	162		<25	
St. Croix					<25		30			381		416			
Taylor				<25	<25		<25			126		92			
Trempealeau					<25		<25			101		55			
Vernon							<25	<25				64			
Walworth				54	50					551		196			
Washburn					<25		<25				<25	46			
Washington					62		59	75		662	93	369			
Waukesha				<25	74		74			1061	<25	689		44	
Waupaca					36	<25				265	<25	29		<25	
Waushara		<25		<25	<25		<25			164		129			
Winnebago				<25	<25	<25	127			1374	1091	319	<25	<25	
Wood					<25		42	45		608		336		52	

Data Source: Program Participation System (PPS), WI Department of Health Services

**Table 12: Count of Consumers Receiving Substance Abuse Services,
by Service Category and County/Region, Wisconsin, 2013**

2013 County/Region	Community Support Program (CSP)	Comprehensive Community Services (CCS)	Community Recovery Services (CRS)	Crisis Intervention / Emergency Outpatient	Detoxification Services	Inpatient Services	Residential Services	Partial Day Services	Court Services	Intake Assessment	Case Management	Outpatient Services	Medication Treatment	Supportive Services	Other Services
Statewide	42	<25	<25	388	4,690	73	1,896	860	478	19,517	10,281	16,606	514	1,325	191
Adams					<25					113		170			
Ashland						<25	<25			124		90	<25		
Barron					<25		<25		<25	105	<25	155		<25	
Bayfield			<25		<25		<25			83	28	43	<25	<25	
Brown		<25		<25	<25		<25			1627	<25	200		<25	
Buffalo	<25				<25		<25				<25	<25			
Burnett					<25		<25				<25	35			
Calumet					<25	<25	<25		<25	282	115	41		<25	
Chippewa					<25		<25					42			
Clark					<25	<25	<25			<25	<25	166			
Columbia				<25	<25	<25	<25		<25	345	<25	156	27	<25	
Crawford					<25		<25			70		61			
Dane					1252		178	162	457	698	1593	1360			33
Dodge				37	69	<25	<25			642	36	220	34	<25	
Door										132	<25	121	26		
Douglas					121		<25			104	<25	55	<25		
Dunn				<25	<25		70	<25		50		157		<25	
Eau Claire	38				83	<25	<25				159	152		48	
Florence							<25			<25		25			
Fond du Lac				79	139		33			497		800			
Forest/Oneida/Vilas					65	<25	177			359	56	515		26	
Grant/Iowa					27		<25			293		347			
Green					<25		<25			206	<25	170	<25		
Green Lake		<25		<25						111		73			
Iron					<25					26		32			
Jackson					<25		<25				<25	57			
Jefferson					66		<25			531	242	300	157		
Juneau					<25		<25			219	<25	128	<25		
Kenosha	<25	<25		57	179		<25			643		299	<25	<25	
Kewaunee				<25					<25	125	99	68		<25	
La Crosse					40		25	<25		714	129	337		42	
Lafayette					<25		<25			113		82			
Lanc/Linc/Marathon					153	<25		108		1695		1104			
Manitowoc					<25		53			377		<25			
Marinette										253	<25	366			
Marquette				<25	<25		<25			146		156		<25	<25
Menominee				<25	<25		<25			132	<25	108		<25	
Milwaukee					1783		505	392			4099	2977	194	534	
Monroe					<25	<25	<25			272	255	130	<25	335	
Oconto					<25		<25			204		127	<25		
Outagamie							130	<25		42	409	170		26	
Ozaukee										344	37	56			
Pepin	<25				<25	<25	<25					<25			
Pierce					<25	<25	<25			176		119			
Polk				<25	<25		<25			336	<25	295		<25	<25
Portage					50		<25			385	358	278		<25	
Price					<25	<25	<25			71	27	<25			
Racine					71					495	977	316			190
Richland									<25	107		95	<25		
Rock	<25				246		<25		<25	1111	<25	497	26	99	
Rusk				<25	<25		<25			65	41	27			
Sauk		<25		53	53		29	<25				116			
Sawyer					<25		<25			168		161		<25	
Shawano				44						289		194			
Sheboygan					<25		64					190			
St. Croix					<25	<25	38	<25		298		373			
Taylor					<25	<25	<25			106	<25	77			
Trempealeau					<25		<25	<25		143		43	<25		
Vernon							<25					66			
Walworth				33	<25					320		187			
Washburn						<25	<25				<25	46			
Washington					50		48	76		616	75	368			
Waukesha					70		103			775	93	757		42	
Waupaca				<25	<25		<25			277		41		<25	
Waushara		<25			<25		<25			227		180	<25		
Winnebago				<25	<25	<25	133			1325	1353	283		<25	
Wood					<25		40	68		598		311		52	

Data Source: Program Participation System (PPS), WI Department of Health Services

The following table lists the substance abuse service categories (combining related SPC service codes) used in the above tables.

Table 13: Substance Abuse Service Categories, with Grouped SPC Service Codes		
Substance Abuse Service Categories	SPC Code(s)	Service(s)
Community Support Program (CSP)	509	
Comprehensive Community Services (CCS)	510, 510.10	
Community Recovery Services (CRS)	511	
Crisis Intervention/Emergency Outpatient	501, 501.10 507.50	Crisis Intervention Emergency Outpatient
Detoxification Services	703.10 703.20 703.50 705, 705.10	Medically Managed Inpatient Detoxification Medically Monitored Residential Detoxification Ambulatory Detoxification Detox (Social Setting, Residential Intoxication Monitoring)
Inpatient Services	503.50 503.60 925	Medically Managed Inpatient Medically Monitored Hospital Treatment Institution for Mental Disease
Residential Services	503.70 504 506.10, 506.20 202, 204 205	Medically Monitored CBRF Treatment Residential Care Center (children) Transitional Residential Adult Family Home, Group Home Shelter Care
Partial Day Services	704.10, 706	Day Treatment (medical, non-medical)
Court Services	301	Court Intake & Studies
Intake Assessment	603	
Case Management	604	
Outpatient Services	507, 507.10, 507.20, 507.30 507.05, 507.15, 507.35 507.40, 507.45	Outpatient, Regular (general, indiv, family, group) Outpatient, Intensive (general, indiv, group) Outpatient, In-home (regular, intensive)
Medication Treatment	507.65 507.70 507.75 507.80	Medication Management Methadone or Narcotic Detoxification Methadone Maintenance / Narcotic Treatment Suboxone Management
Supportive Services	101 104, 104.10, 106 107 108 110 507.64 601 602, 602.10 606 615	Child Care Home Supports Specialized Transportation & Escort Work Related Services Daily Living Skills Training Drug Testing Outreach Information and Referral Health Screening & Accessibility Supported Employment
Other Services	112 112.55 403 406 408 507.62	Interpreter Services / Adaptive Equipment Specialized Medical Supplies Recreation / Alternative Activities Protective Payment / Guardianship Community Prevention / Organization/Awareness Other medical services

Data Source: Program Participation System (PPS), WI Department of Health Services

Wisconsin and National Service Distribution

The table below compares Wisconsin's substance abuse services array with the average array of services across the United States. Wisconsin continues to provide a smaller percentage of residential and intensive outpatient treatment services (and a larger percentage of regular outpatient services) than the national average.

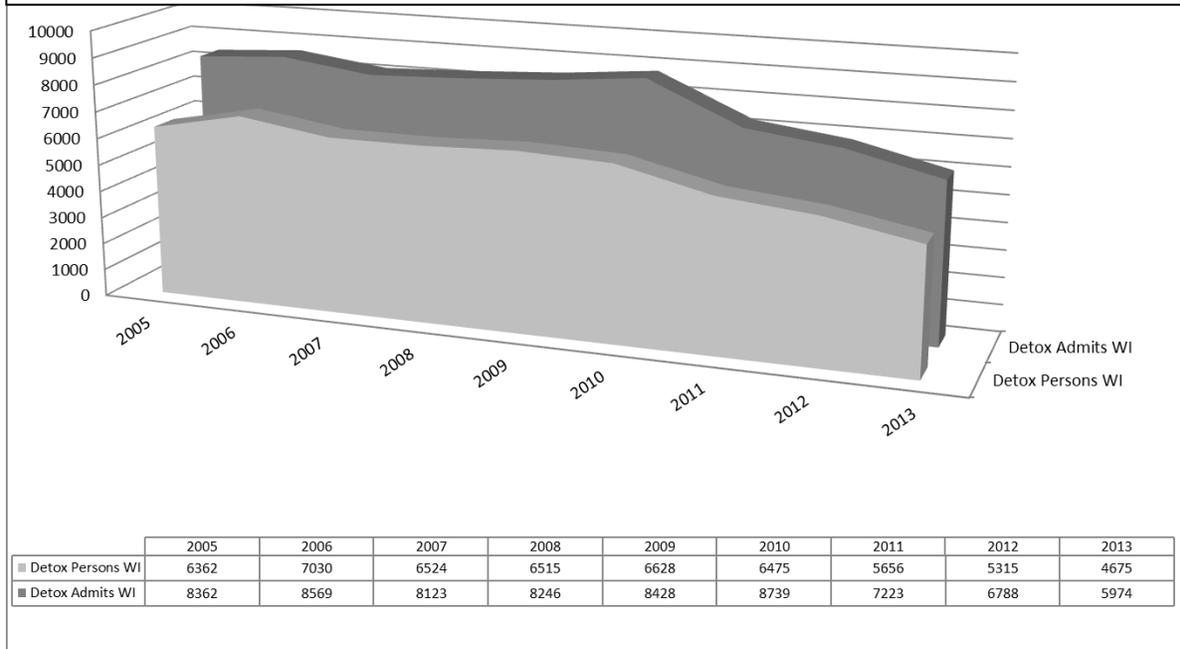
Substance Abuse Service	WI, 2013	U.S., 2012
Detox	19.5%	22.8%
Inpatient	0.2%	0.3%
Residential, short-term (30 days or less)	1.3%	9.2%
Residential, long-term (more than 30 days)	4.5%	7.5%
Intensive outpatient or day treatment	5.1%	12.0%
Regular outpatient	69.4%	48.2%
All Substance Abuse Services	100.0%	100.0%

Data Source: Treatment Episode Data Set, SAMHSA; Program Participation System (PPS), WI Department of Health Services.

Detoxification Services

Alcohol and certain other drug withdrawal can be life threatening. Detoxification services provide a protective environment for the safe withdrawal of alcohol and other drugs from the body and an opportunity for the client to get connected with continuing treatment. Detox is a medically necessary service, however, repeated detox episodes can, in some instances, be prevented. The decline in publically-supported detox services (seen in the chart below) includes a slight decrease in repeat detox episodes from an average of 1.35 admissions per person in 2010 (8739 admits among 6475 persons) to 1.28 admissions per person in 2011 through 2013.

Figure 13: Number of Detox Persons and Admissions, Wisconsin, 2005-2013



Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

Medication-Assisted Treatment

The use of medications such as Naltrexone, Buprenorphine and Methadone to supplement psychosocial addiction treatment is an evidence-based approach to care. According to data on the percent of client admissions that include medication services (in the table below), Wisconsin lags behind the national average in the use of medication adjuncts.

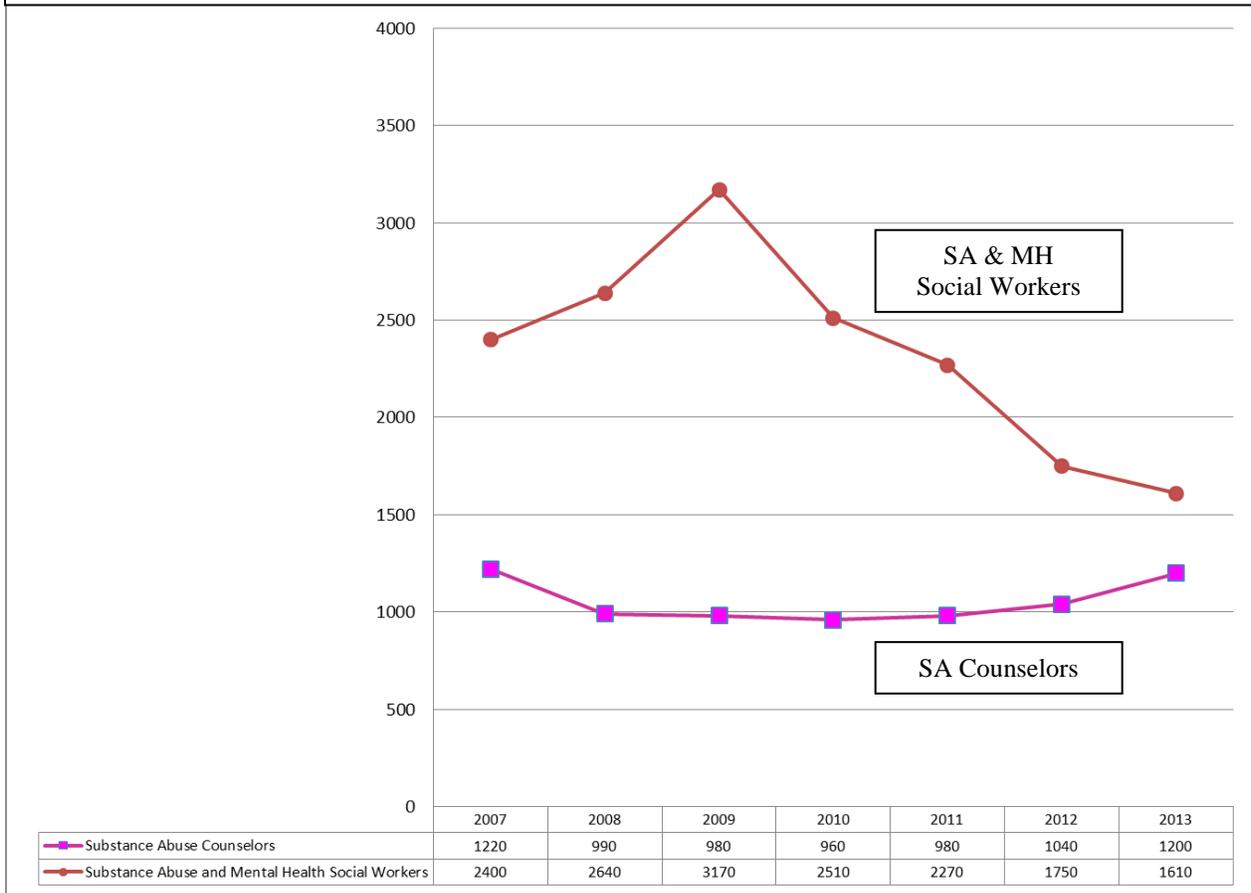
Table 15: Percent of Client Admissions that Received Medication-Assisted Treatment, Wisconsin 2013 and United States 2012	WI, 2013	U.S., 2012
	0.3%	6.8%

Data Source: Treatment Episode Data Set, SAMHSA

Substance Abuse Treatment Workforce

In 2013, there were an estimated 1,200 employed substance abuse (SA) counselors in Wisconsin and another 1,610 substance abuse and mental health (SA & MH) social workers. While the U.S. Bureau of Labor Statistics is projecting a 33% increased need for substance abuse professionals by the year 2016, Wisconsin has seen an overall decline in its substance abuse treatment workforce since 2009 (with only a 1% gain between 2012 and 2013).

Figure 14: Substance Abuse Treatment Workforce in Wisconsin, 2007-2013



Data Source: U.S. Bureau of Labor Statistics

Substance Abuse Service Availability and Waiting List Issues

Each year the Wisconsin Division of Mental Health and Substance Abuse Services gathers data from county agencies administering or providing substance abuse services. Data on waiting lists and unavailable services are collected. In 2013, 530 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 1,660 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. Thirty County agencies identified services that were not available due to lack of sufficient revenue such as residential or housing services, narcotic treatment, intensive outpatient counseling, case management, wrap-around services and transportation.

IV. Quality and Outcomes

The purpose of this section is to examine to what degree consumers are treated effectively in Wisconsin's MH/AODA service system. Two broad areas will be examined:

- Quality and Appropriateness of Services
- Consumer Outcome Indicators

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.

Quality and Appropriateness of Services

Two important issues related to the quality and appropriateness of services received by consumers are examined in this section:

- Using evidence-based practices to deliver quality services with proven effectiveness
- Delivering services in a Recovery-based manner

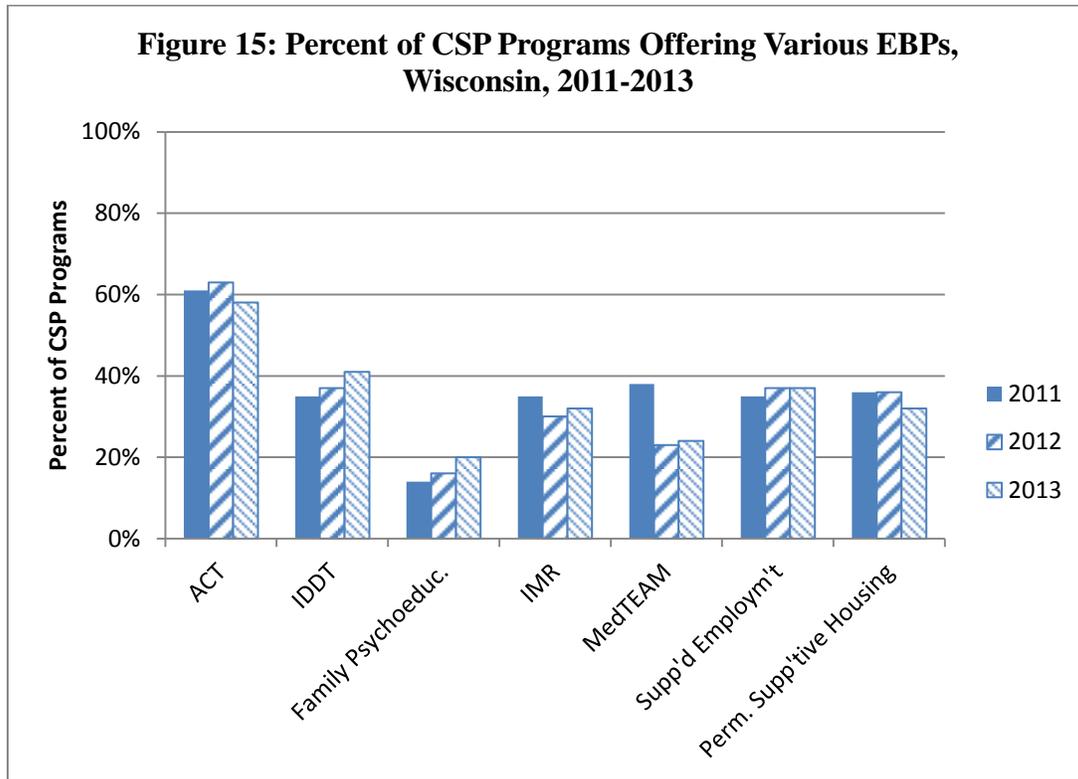
Use of Evidence-Based Practices to Provide Quality Mental Health Services

The Division of Mental Health and Substance Abuse Services (DMHSAS) conducts an annual program survey of all CSPs and CCSs across the state. These surveys have asked program staff for information on their use of evidence-based practices (EBPs) among CSPs since 2007 and CCSs since 2011. The DMHSAS provided grant funding to select counties from 2006-2008 to implement EBPs for adults in CSPs and has more recently funded training for Supported Employment, but counties and CSPs have been on their own otherwise to select and implement EBPs.

Community Support Programs (CSPs)

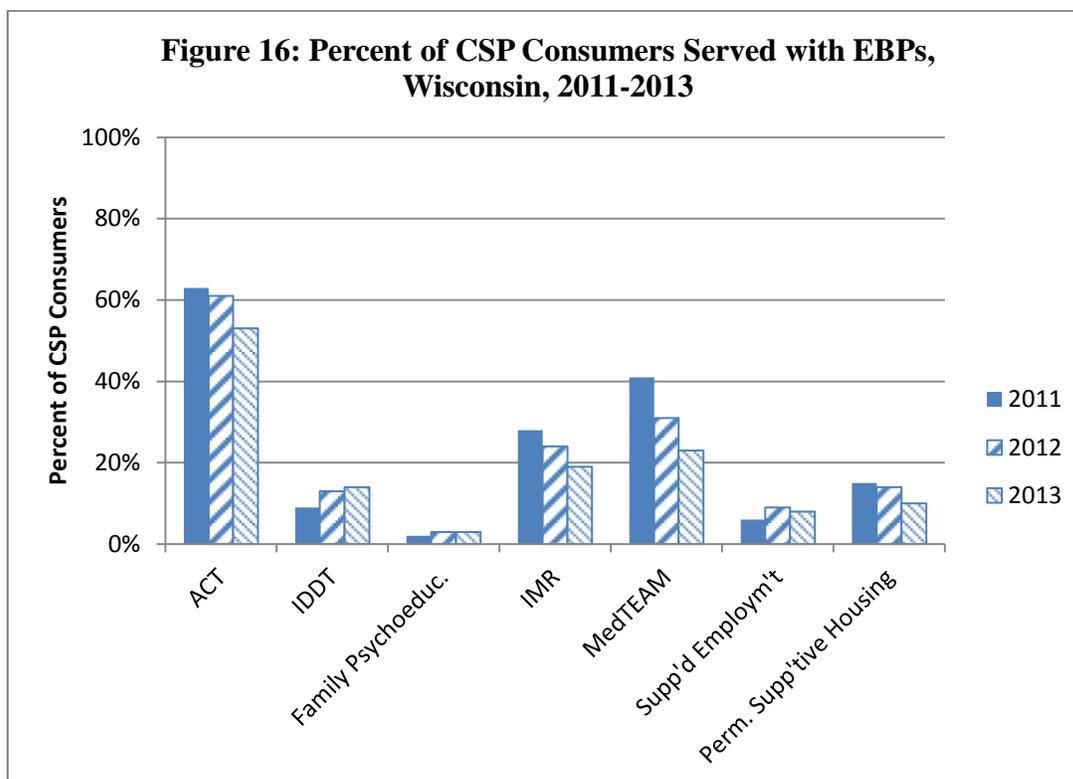
About eighty percent of CSPs offered at least one EBP to their consumers and many (almost one in every five CSPs) offered five or more EBPs. The types of EBPs offered by CSPs over the past three years (2011-2013) are displayed in the chart below. Since the CSP model was originally based on a variation of ACT, it is not surprising that of the CSPs responding to the program surveys each year, Assertive Community Treatment (ACT) was the most common EBP, offered by about 60% of the programs. Integrated Dual Disorder Treatment (IDDT), Illness Management and Recovery (IMR), Supported Employment, and Permanent Supportive Housing were offered by about one third of the programs while MedTEAM and Family Psychoeducation were even

less common, offered by less than a quarter of CSPs. Very few programs (about 10%) offered any EBPs beyond the list provided in the survey. However, several programs mentioned that they offered Motivational Interviewing (MI), Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), and Peer Specialists/Peer Support.



Data Source: CSP Annual Program Surveys, WI Department of Health Services

Most CSP programs offered at least one EBP, but the percent of consumers actually served using those EBPs remained fairly low. ACT was the only EBP received by more than half of all CSP consumers each year (2011-2013). MedTeam and IMR services were somewhat less common (received by two to four of every ten CSP consumers), but all other models were received by relatively few (only about 10%) of CSP consumers.



Data Source: CSP Annual Program Surveys, WI Department of Health Services

The program surveys also asked CSPs to report on the degree to which they implemented EBPs that are faithful to the prescribed treatment model, ensuring they provide high quality and effective services. CSPs were asked to report on several aspects of the implementation of each EBP, including:

- Have CSP staff been specifically trained to implement this EBP?
- Did you use the official EBP toolkits to guide your implementation?
- Did you monitor the fidelity of your implementation?
- Did you use an outside monitor to review fidelity?

The first issue of EBP provision is to what degree CSPs implemented ACT, the model on which CSPs are based. Of the CSPs who used ACT, almost 90% trained their staff to implement the model; however, just over half used the official ACT implementation toolkit to guide implementation. Generally less than half of all CSPs that use ACT monitored the fidelity of their implementation of the model, and most monitored their own fidelity rather than enlisting an independent outside monitor.

Many CSPs noted that their main obstacle to faithfully applying the ACT model was meeting the maximum consumer-to-staff ratio (10:1) that ACT requires. Staffing shortages are thus a significant barrier to meeting this best practice. For those using ACT, more emphasis may be needed on using the official ACT toolkit, including its fidelity measures. A similar pattern of implementation exists for the other EBPs used among CSPs as well.

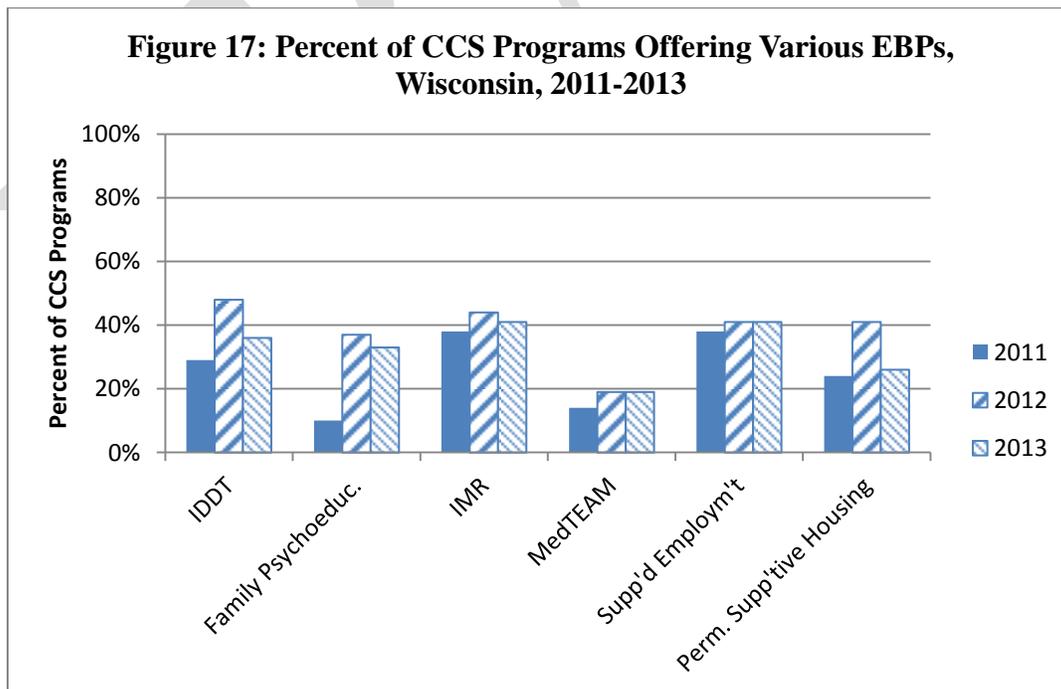
Implementation Step	2011	2012	2013
Trained Staff	86%	89%	88%
Used Toolkits	57%	61%	56%
Monitored Fidelity	52%	43%	41%
Outside Monitor	14%	7%	10%

Data Source: CSP Annual Program Surveys, WI Department of Health Services

Comprehensive Community Services (CCSs)

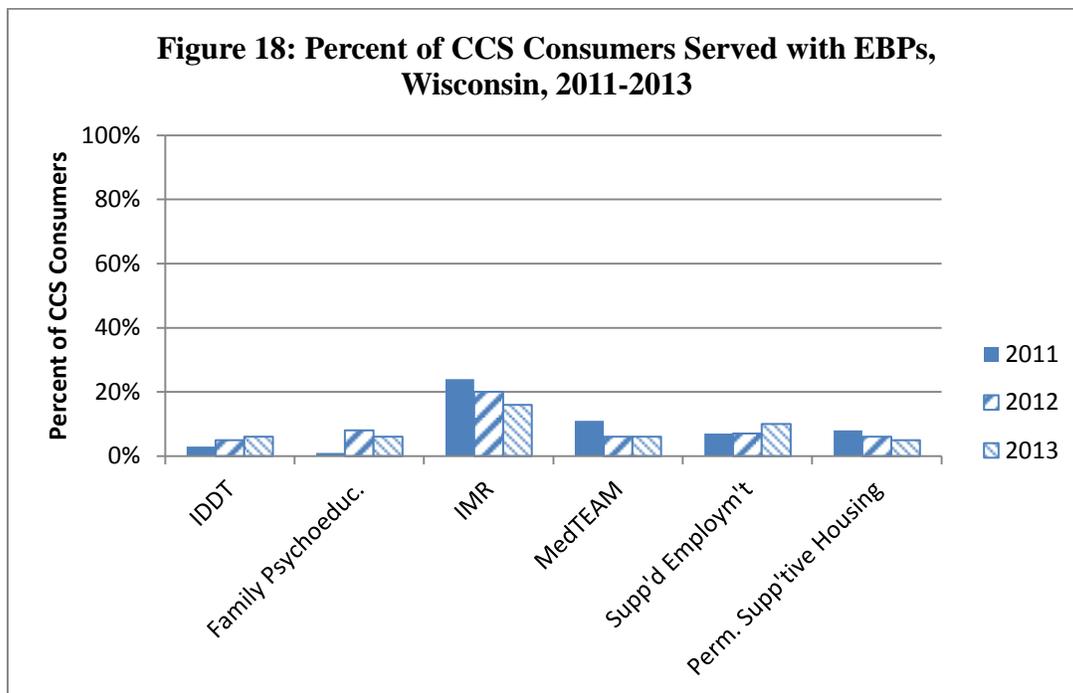
While CCSs are not required to use EBPs, they are encouraged to incorporate EBPs to the best of their ability. Between 2011 and 2013, about two-thirds (between 62% and 67%) of CCS programs offered at least one EBP to their consumers; each year, several programs reported offering as many as 5 or more EBPs.

The types of EBPs offered by CCSs are displayed in the chart below. Integrated Dual Disorder Treatment (IDDT), Illness Management and Recovery (IMR), Supported Employment, and Family Psychoeducation were generally the most common EBPs, offered, available in about 40% of CCS programs. Permanent Supportive Housing and MedTEAM were less common, offered by less than a quarter of CCSs.



Data Source: CCS Annual Program Surveys, WI Department of Health Services

While many CCS programs offered at least one EBP to their consumers, the percent of consumers receiving those EBPs remained very low. IMR was the only EBP received by 20% of all CCS consumers (and then only in 2011 and 2012). All other EBP services were received by 10% or less of CCS consumers.



Data Source: CCS Annual Program Surveys, WI Department of Health Services

The degree to which CCSs faithfully implemented those EBPs they did provide was asked in the CCS program survey (as it was for CSP programs). CCSs reported on various aspects of EBP implementation including: staff training; use of toolkits; monitoring fidelity; and use of outside monitors. The following table shows the percent of CCSs who took each of these four implementation steps (among those programs that offered each EBP).

While CCS staff were often trained to administer an EBP, the toolkits provided by the Substance Abuse and Mental Health Services Administration (SAMHSA)¹ to guide implementation of an EBP were used less consistently. And although some programs did monitor the fidelity with which they implemented EBPs, monitors from outside the CCS were rarely used to assess fidelity (with the notable exception of Supported Employment).

[Note: In 2011, some programs reported training staff in using an EBP despite not offering it to consumers that year; this may reflect preparation for using an EBP rather than reporting error.]

¹ SAMHSA Toolkits on Evidence-Based Practices (EBP), see: <http://store.samhsa.gov/pages/searchResult/ebp+kit>

Table 17: CCS Implementation of Various EBPs, by Implementation Step, Wisconsin, 2011-2013			
IDDT	2011	2012	2013
Trained Staff	67%	92%	100%
Used Toolkits	67%	46%	67%
Monitored Fidelity	50%	38%	50%
Outside Monitor	33%	8%	10%
Family Psychoeducation	2011	2012	2013
Trained Staff	150%	80%	78%
Used Toolkits	100%	50%	56%
Monitored Fidelity	50%	40%	56%
Outside Monitor	0%	10%	0%
IMR	2011	2012	2013
Trained Staff	125%	83%	91%
Used Toolkits	50%	58%	82%
Monitored Fidelity	38%	50%	55%
Outside Monitor	0%	17%	9%
MedTEAM	2011	2012	2013
Trained Staff	100%	100%	100%
Used Toolkits	67%	60%	80%
Monitored Fidelity	67%	60%	40%
Outside Monitor	33%	20%	0%
Supported Employment	2011	2012	2013
Trained Staff	88%	82%	90%
Used Toolkits	25%	73%	60%
Monitored Fidelity	50%	64%	63%
Outside Monitor	63%	36%	36%
Permanent Supportive Housing	2011	2012	2013
Trained Staff	80%	82%	57%
Used Toolkits	20%	36%	29%
Monitored Fidelity	20%	27%	29%
Outside Monitor	0%	18%	0%

Data Source: CCS Annual Program Surveys, WI Department of Health Services

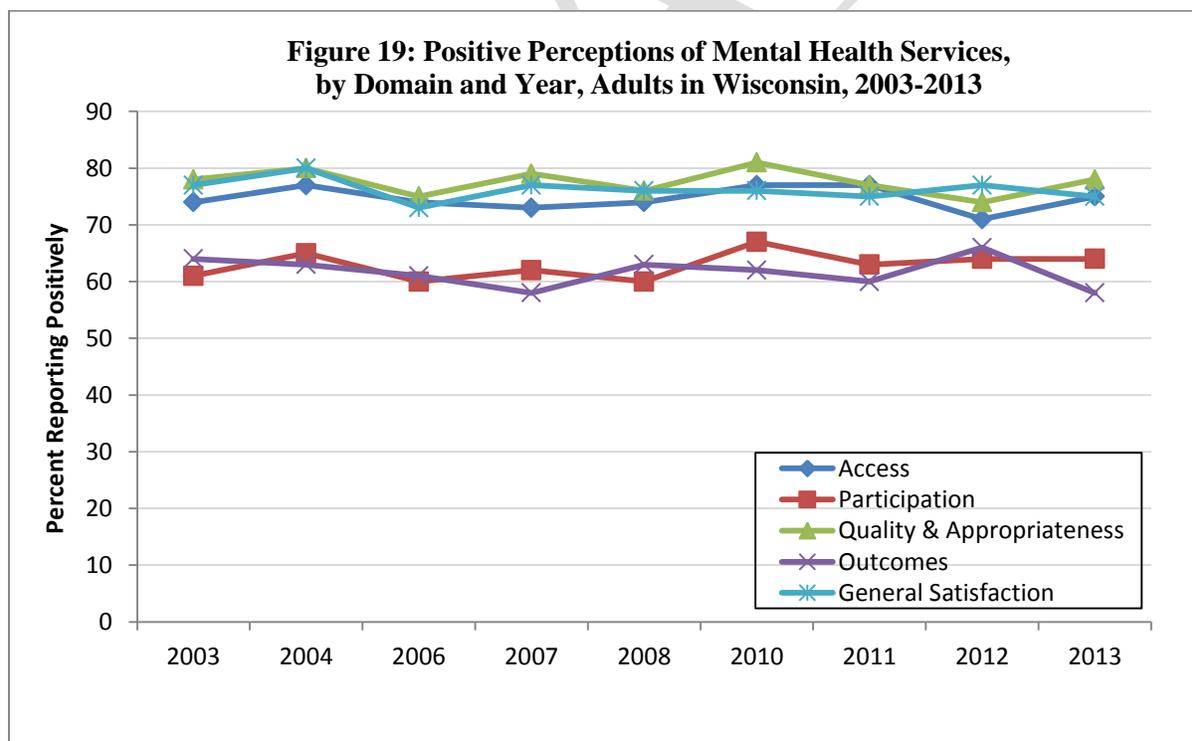
Delivering Services in a Recovery-based Manner

Consumer Satisfaction with Mental Health Services

Every year, the Wisconsin Division of Mental Health and Substance Abuse Services (DMHSAS) distributes a satisfaction survey to a random sample of consumers served in the county mental health system across the state. The survey is administered to adult consumers with serious mental illness (SMI) and the primary caregivers of youth ages 6-17. Updated consumer satisfaction data through 2013 is included below. Consumer satisfaction levels are very similar to results described in the original Needs Assessment report for previous years.

Highlights of adult consumers' satisfaction with their mental health services include:

- Adult consumers were consistently satisfied with the mental health services they received between 2003 and 2013. Levels of general satisfaction have not varied much over time, remaining between 73%-80% across the ten years.
- Adults' satisfaction with the quality and appropriateness of their mental health services also has been high (74%-81%) compared to other domains; their satisfaction with access to services (71%-77%) also has remained consistently high.
- Adult consumers have been satisfied with their participation in treatment planning over time (levels of satisfactions ranging from 60% to 67%); however, as many as 4 of 10 adults are neutral or unsatisfied about their participation in treatment planning.



Data Source: Annual MHSIP Satisfaction Surveys, WI Department of Health Services

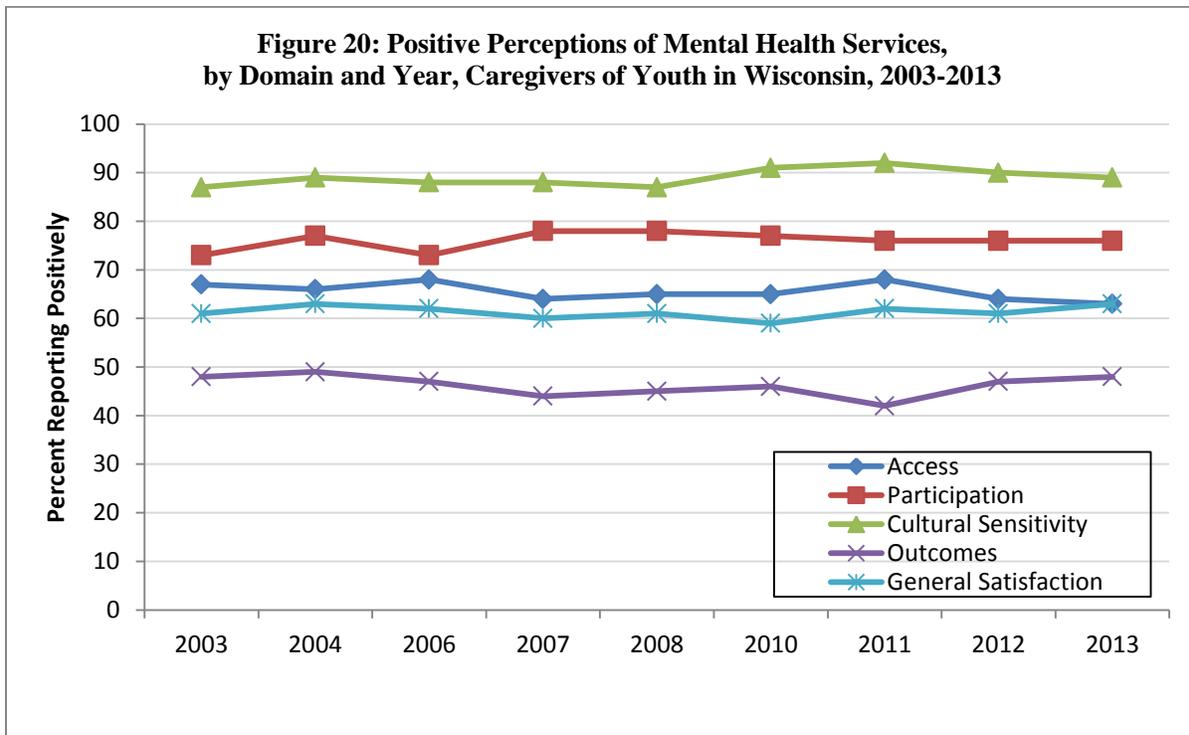
Year	Quality &			Outcomes	General Satisfaction
	Access	Participation	Appropriateness		
2003	74	61	78	64	77
2004	77	65	80	63	80
2006	74	60	75	61	73
2007	73	62	79	58	77
2008	74	60	76	63	76
2010	77	67	81	62	76
2011	77	63	77	60	75
2012	71	64	74	66	77
2013	75	64	78	58	75

Data Source: Annual MHSIP Satisfaction Surveys, WI Department of Health Services

A summary of caregivers' satisfaction with the quality and appropriateness of their child's treatment include:

- Similar to adults, the highest rated domain for youth was related to quality and appropriateness. Satisfaction with the cultural sensitivity of youth services was consistently high (between 87% and 92% over time).
- Caregivers were more satisfied (73-78%) with the level of participation in planning their child's services than adult consumers were with participation in their own treatment.

Although aspects of the quality of consumers' experiences with mental health services were rated relatively high, it did not appear to result in improved functional outcomes for everyone. Adults appear to be relatively unsatisfied with the outcomes associated with the services they received: less than two-thirds (58%-66%) reported that services had made a positive impact on their lives. Caregivers were even less satisfied with the outcomes associated with services their child had received: less than half (42%-49%) reported that their children's services had resulted in positive outcomes. In most years, over three-quarters (75%) of adult consumers were satisfied with the quality of their services, but less than two-thirds (66%) were satisfied with the functional outcomes of their services. The gap for youth is even greater: nearly 90% of caregivers were satisfied with the cultural sensitivity of services and their participation in treatment planning, but always less than half of caregivers were satisfied with the outcomes of their children's services.



Data Source: Annual MHSIP Satisfaction Surveys, WI Department of Health Services

**Table 19: Positive Perceptions of Mental Health Services,
by Domain and Year, Caregivers of Youth in Wisconsin, 2003-2013**

Year	Access	Participation	Cultural Sensitivity	Outcomes	General Satisfaction
2003	67	73	87	48	61
2004	66	77	89	49	63
2006	68	73	88	47	62
2007	64	78	88	44	60
2008	65	78	87	45	61
2010	65	77	91	46	59
2011	68	76	92	42	62
2012	64	76	90	47	61
2013	63	76	89	48	63

Data Source: Annual MHSIP Satisfaction Surveys, WI Department of Health Services

A summary of caregivers' satisfaction with the quality and appropriateness of their child's treatment include:

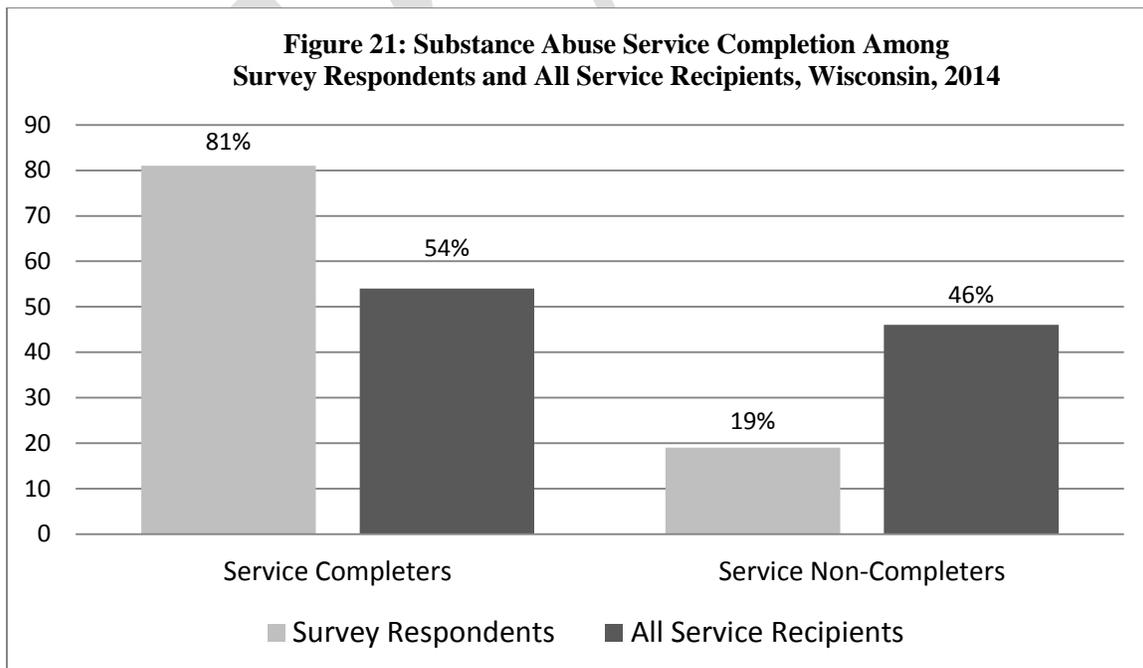
- Similar to adults, the highest rated domain for youth was related to quality and appropriateness. Satisfaction with the cultural sensitivity of youth services was consistently high (between 87% and 92% over time).
- Caregivers were more satisfied (73-78%) with the level of participation in planning their child's services than adult consumers were with participation in their own treatment.

Although aspects of the quality of consumers’ experiences with mental health services were rated relatively high, it did not appear to result in improved functional outcomes for everyone. Adults appear to be relatively unsatisfied with the outcomes associated with the services they received: less than two-thirds (58%-66%) reported that services had made a positive impact on their lives. Caregivers were even less satisfied with the outcomes associated with services their child had received: less than half (42%-49%) reported that their children’s services had resulted in positive outcomes. In most years, over three-quarters (75%) of adult consumers were satisfied with the quality of their services, but less than two-thirds (66%) were satisfied with the functional outcomes of their services. The gap for youth is even greater: nearly 90% of caregivers were satisfied with the cultural sensitivity of services and their participation in treatment planning, but always less than half of caregivers were satisfied with the outcomes of their children’s services.

Consumer Satisfaction with Substance Abuse Services

A first ever Wisconsin statewide survey of client satisfaction with substance use services was completed in the fall of 2014. The purpose of the mailed survey is to gauge the quality of and satisfaction with services delivered through substance use counseling programs and to identify areas for service quality improvement efforts. Two hundred eighty-six (286) service recipients from 44 of Wisconsin’s 72 counties returned completed surveys.

Customer satisfaction surveys of this kind can have a couple sources of bias which may skew or inflate the results in a positive direction. First, persons are typically more likely to return a survey if they have completed alcohol or drug abuse counseling services. To give the reader an idea of the amount of this bias contained in the survey, we compared service completion percentages among survey respondents and a DHS database of all service recipients: 81% of survey respondents completed counseling services, compared with only 54% of all service recipients.



Data Source: Survey of Client Satisfaction with Substance Abuse Services, WI Department of Health Services; & Program Participation System (PPS), WI Department of Health Services.

Also, service completers tend to report a higher rate of satisfaction with services than consumers who did not complete services.

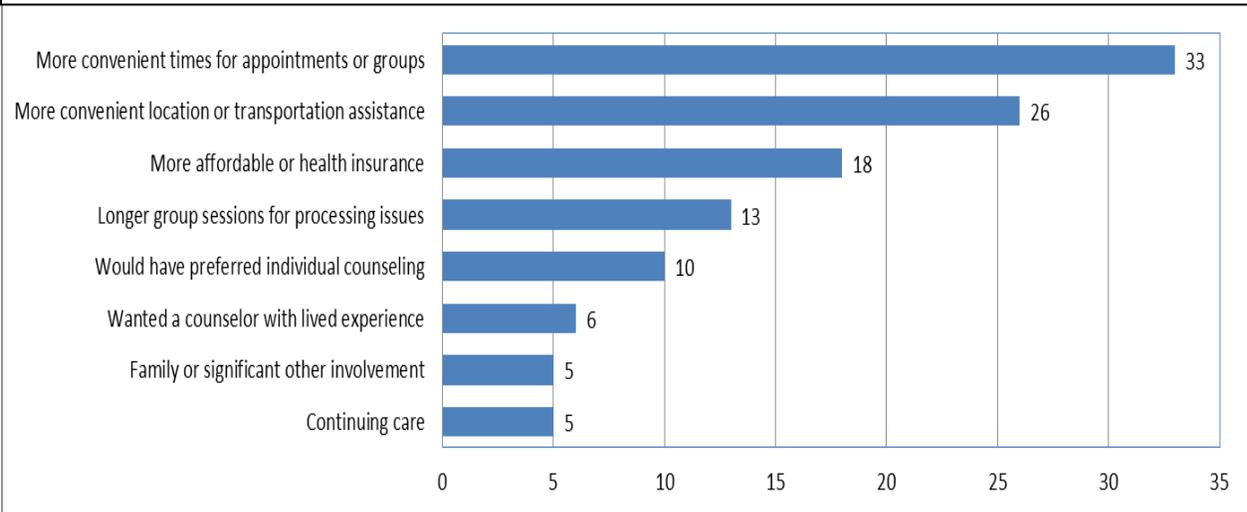
- Among survey respondents *who completed services*, 86% indicated that the alcohol/drug counseling they received was a positive experience, 84% said they would recommend the services to others and 78% said services helped them; an average of these three satisfaction indicators for service completers is 83%.
- In contrast, among survey respondents *who did not complete services*, 66% indicated that the alcohol/drug counseling they received was a positive experience, 70% would recommend services to others and 53% said services helped them; an average of these three satisfaction indicators for service non-completers is 63%.

For both these reasons, it is important to adjust the survey findings to take into account the imbalance of service completers among survey respondents. Using the average levels of satisfaction among service completers and non-completers, the average satisfaction rate among survey responders would be an adjusted 74% (if survey respondents had been more representative of all service recipients) compared with an un-adjusted 80%.

How does the Wisconsin average service satisfaction rate of 74% compare? There is an indication that the Wisconsin alcohol/drug counseling satisfaction rate may be on par with or slightly higher than those reported in published studies. In surveys by Friedmann (2008) [Patient satisfaction and sustained outcomes of drug abuse treatment, *Journal of Health Psychology*, 13(3)] and Carlson (2001) [Patient satisfaction, use of services and one-year outcomes in publicly funded substance abuse treatment, *Psychiatric Services*, 52(9)], rates of alcohol and drug service satisfaction ranged from 65% to 75%. The MHSIP survey, conducted each year by the state Division of Mental Health and Substance Abuse Services, has found unadjusted mental health service satisfaction rates from Wisconsin adults ranging from 78% to 82%.

In an effort to improve the quality of services provided, respondents of the substance abuse services survey also were asked, “What would have made services better for you?” The chart below summarizes their input.

Figure 22: Count of Respondents, by How Services Could be Made Better, Wisconsin, 2014



Data Source: Survey of Client Satisfaction with Substance Abuse Services, WI Department of Health Services

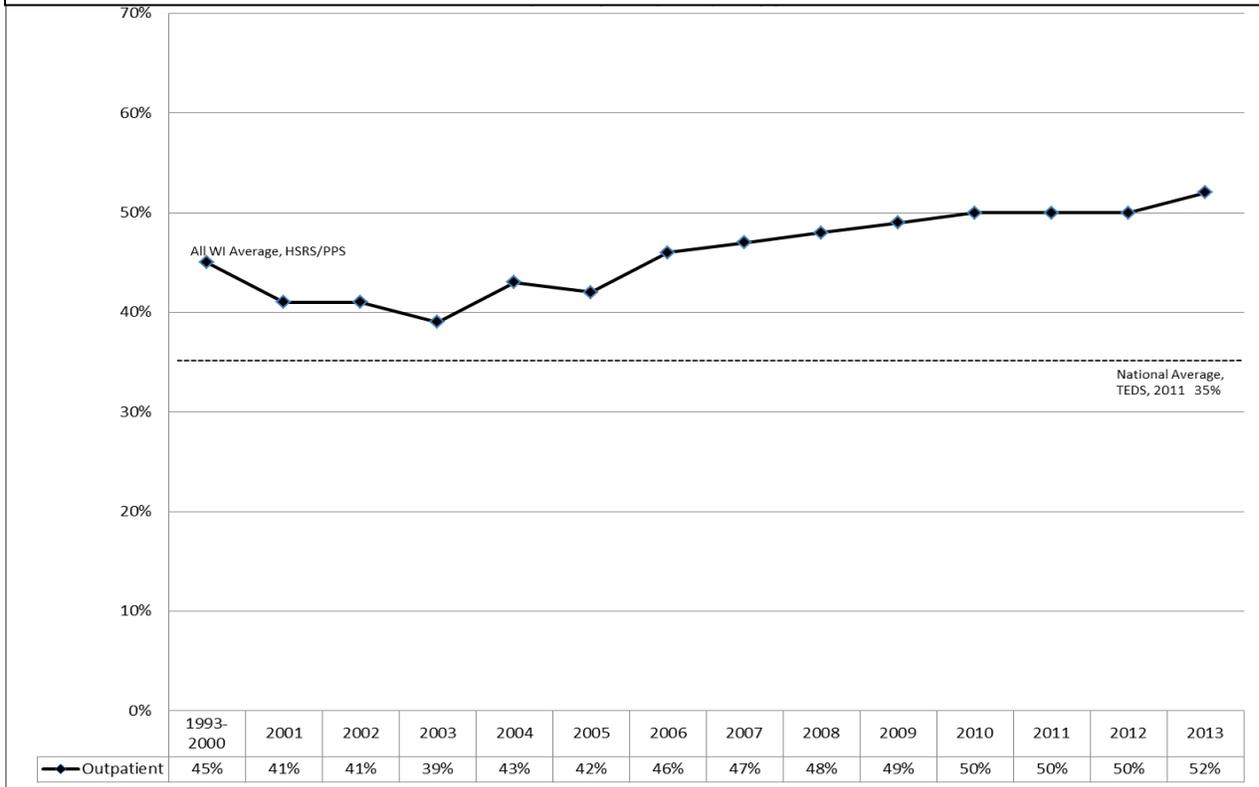
Consumer Outcome Indicators

Treatment Completion

Three decades of research has demonstrated that substance abuse treatment completion is strongly associated with positive post-discharge social functioning outcomes. 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 20 years (among the approximately 18,000 consumers discharged from substance abuse outpatient treatment each year). The increase in treatment completion seen in 2006 and the years that follow is a result of the Department of Health Services' STAR-QI quality improvement program which consists of 45 substance abuse and mental health treatment providers pursuing various service quality improvement projects. The national outpatient treatment completion average in 2011, depicted by the dashed line, was 35%.

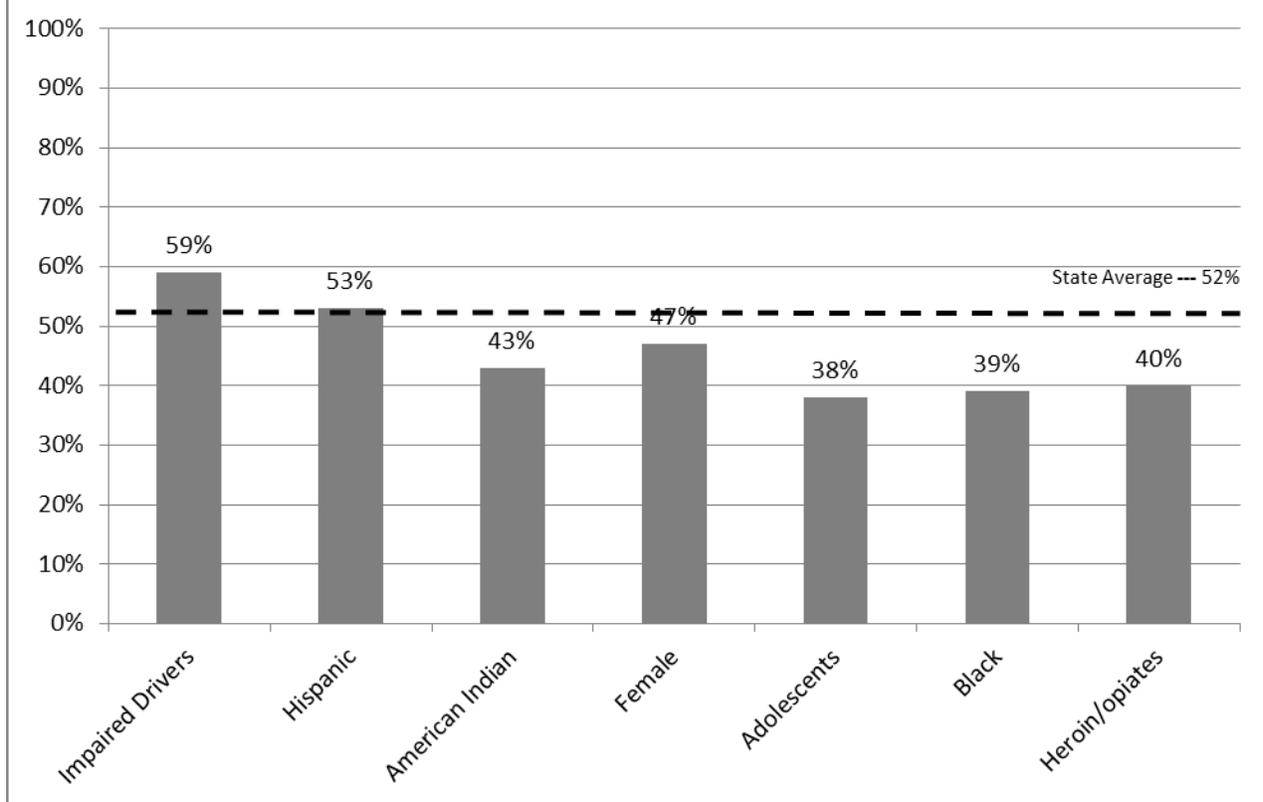
Figure 23: Substance Abuse Outpatient Treatment Completion Rates, Wisconsin & U.S. Average, 1993-2013 (n ~ 18,000 per year)



Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

While the overall statewide rate of outpatient treatment completion in Wisconsin exceeds the national average, disparities in treatment completion rates exist among several Wisconsin population groups for which data are available. Treatment completion rates in 2013 fall below the state average of 52% (dotted line in the following chart) for African Americans, American Indians, females, adolescents, and heroin/opiate abusing clients.

Figure 24: Substance Abuse Outpatient Treatment Completion Rates, Among Various Population Groups, Wisconsin, 2013

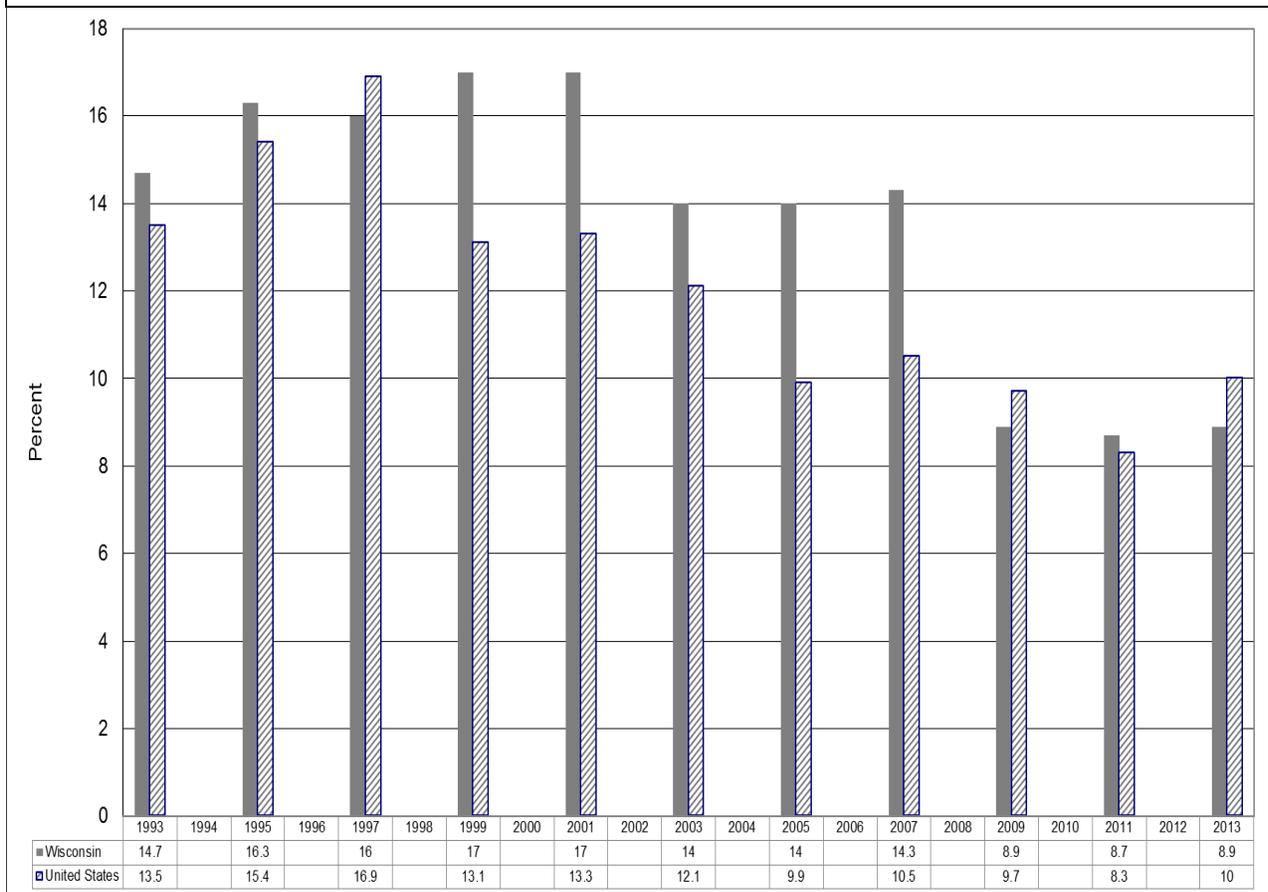


Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services

Substance Abuse Prevention Effectiveness

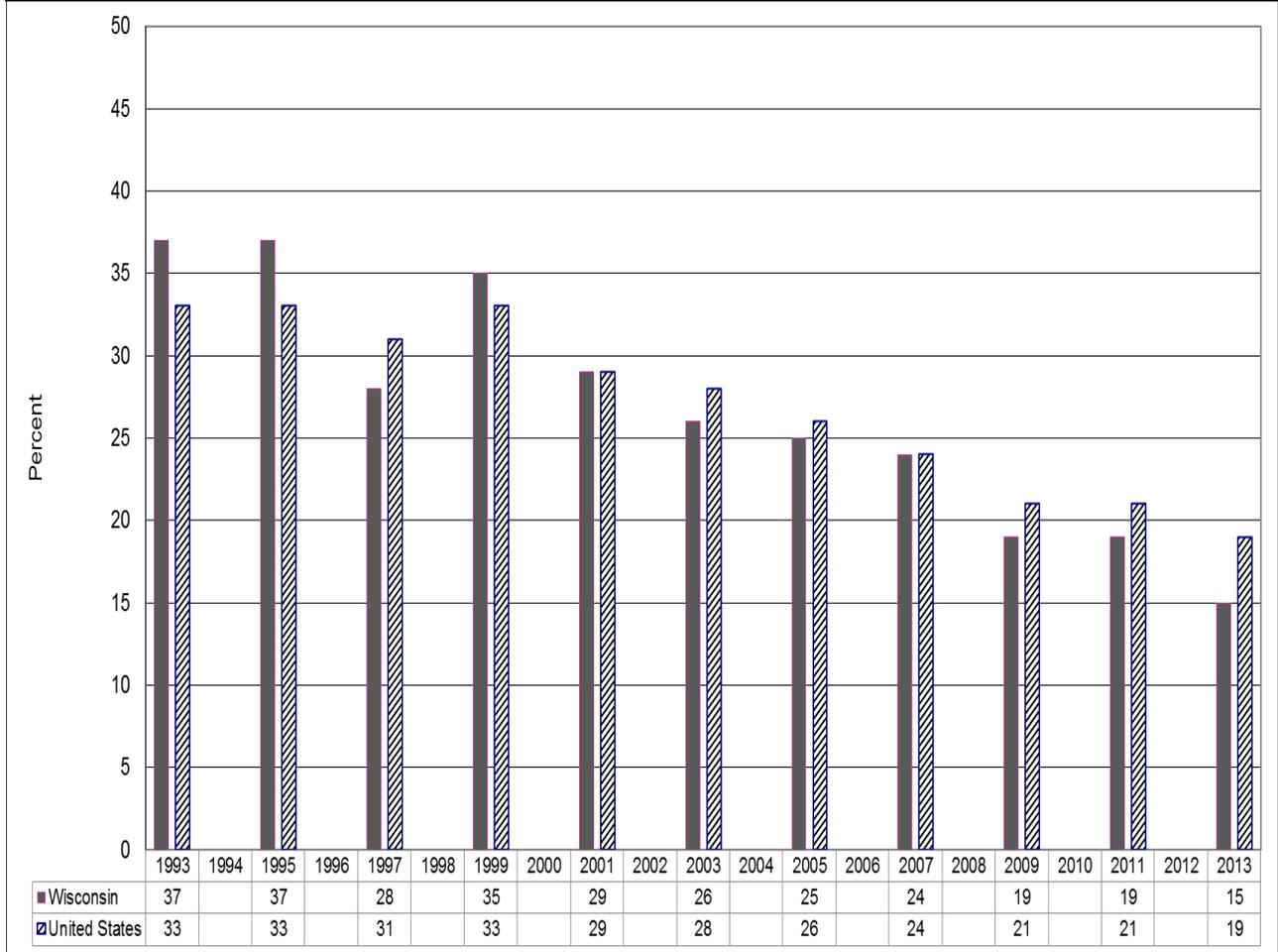
The two charts that follow provide an update on two indicators of the effectiveness of Wisconsin prevention programs and strategies. Reported driving after drinking among Wisconsin high school students fell markedly after 2007 and remains below the national average in 2013. The percent of Wisconsin youth who report having their first full drink of alcohol before age 13 has dropped steadily since 1999 (along with the percent among U.S youth) and has remained at or below the national average since 2001.

Figure 25: High School Students Reporting Driving After Drinking Alcohol, In the Past 30 Days, Wisconsin and United States, 1993-2013



Data Source: Youth Risk Behavior Survey (YRBS), Centers for Disease Control and Prevention (CDC)

Figure 26: First Use of Alcohol Prior to Age 13, Wisconsin and United States, 1993-2013

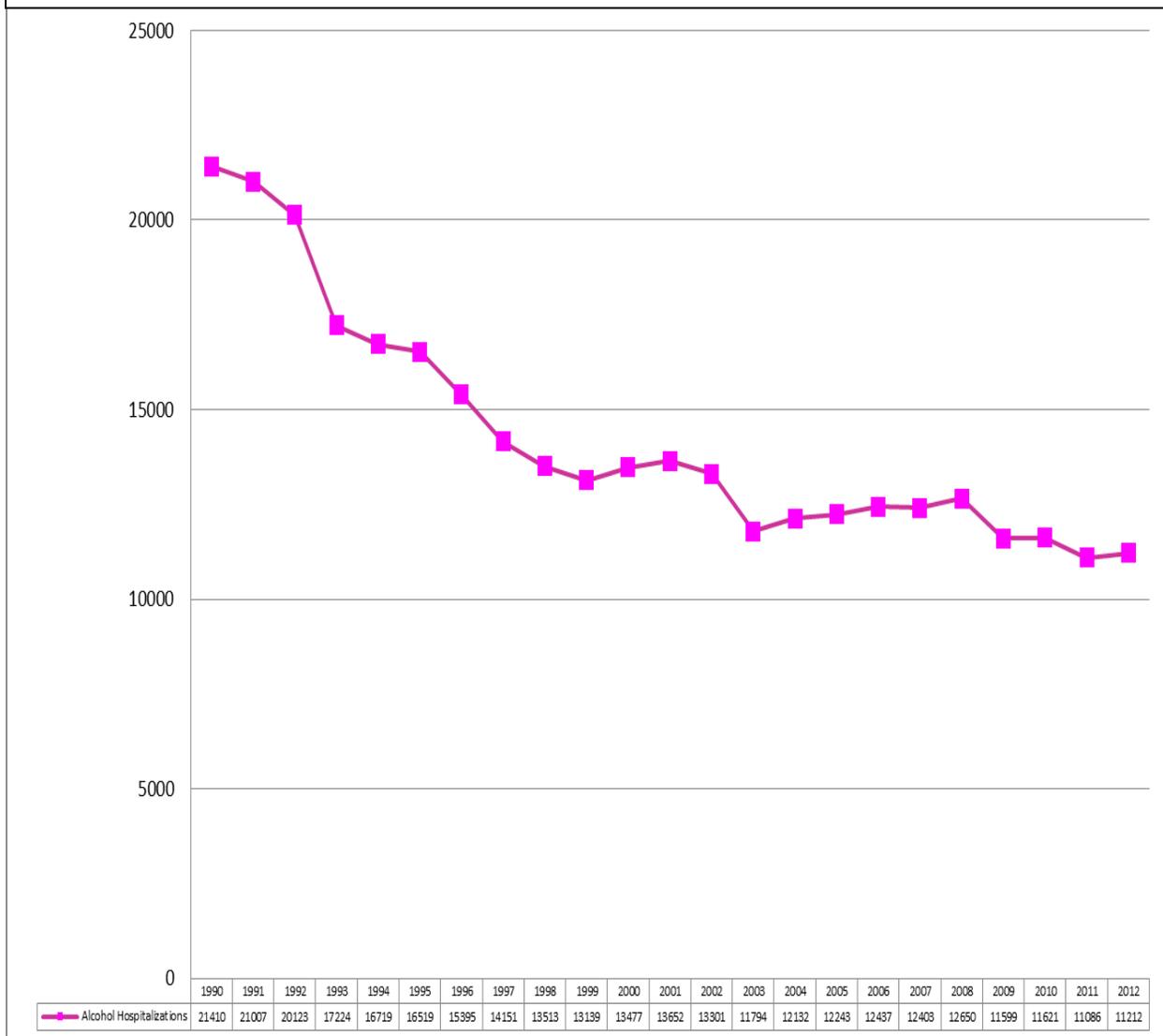


Data Source: Youth Risk Behavior Survey (YRBS), Centers for Disease Control and Prevention (CDC)

Alcohol-Related Hospitalizations

It is important to track hospitalizations for alcohol-related conditions such as acute poisoning/toxicity, liver cirrhosis, pancreatitis and alcoholism. There were at least 11,212 alcohol-related hospitalizations reported in 2012 (most recent year available), down from the previous 5-year average of 11,873 and the lowest number (aside from 2011) recorded over the past 20 years.

Figure 27: Number of Alcohol-Related Hospitalizations, Wisconsin, 1990-2012



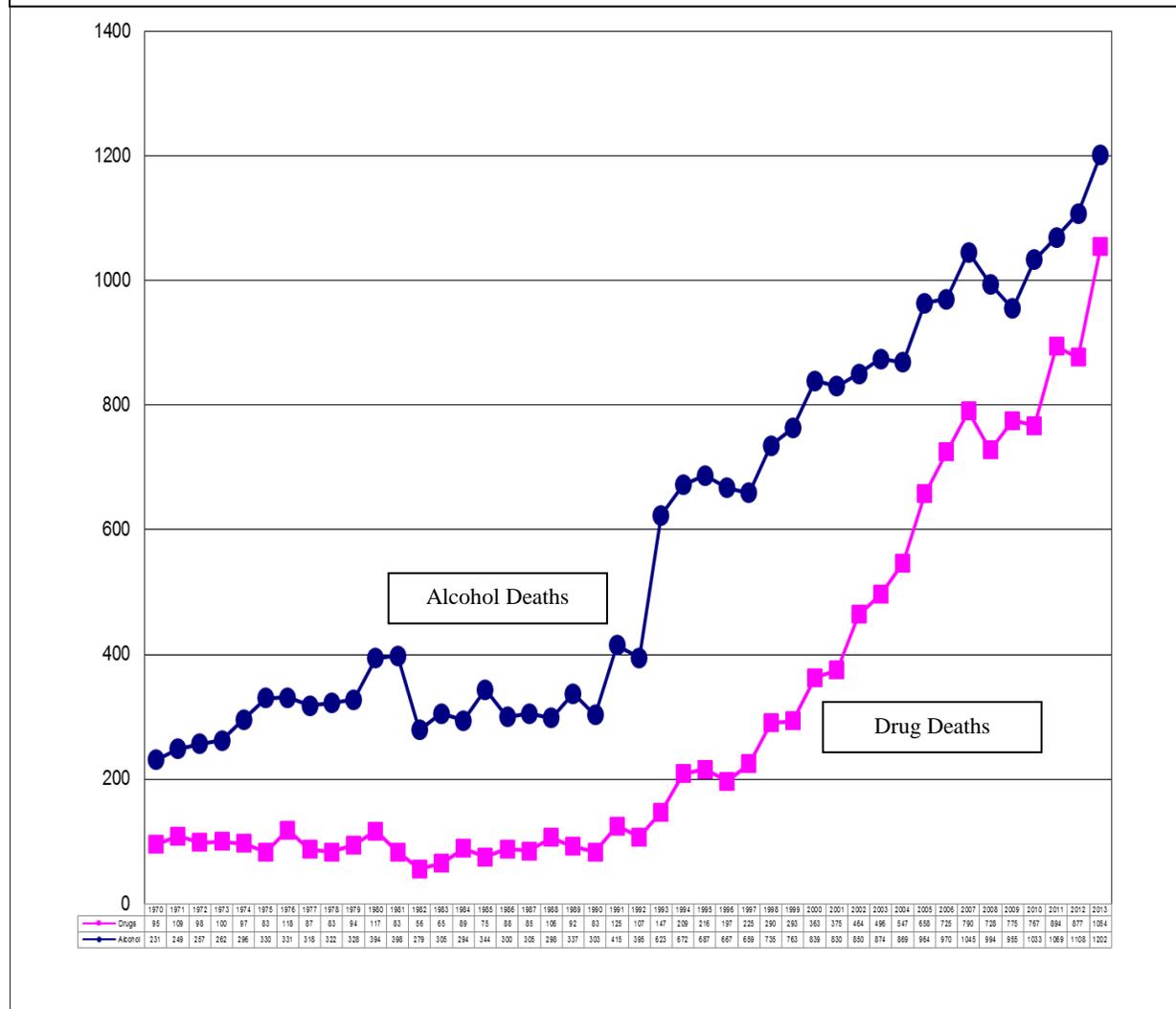
Data Source: Hospital Inpatient Discharge Database, Office of Health Informatics, WI Department of Health Services

Alcohol- and Drug-Related Mortality

Conditions such as liver cirrhosis, pancreatitis, hepatitis C, overdose and addiction are included in cause of death figures collected from Wisconsin death certificates. All causes of death combined, a total of 50,000 deaths occurred across Wisconsin in 2013; the leading causes of death were heart disease, cancer, and stroke.

More in-depth examination and accurate reporting of the underlying cause of death in recent years is in part responsible for an increase in reported deaths related to habit-forming illicit drugs and medications and alcohol. However, extreme unhealthy and life-threatening use of these substances continues to rise in Wisconsin, resulting in increased alcohol- and drug-related mortality. Largely preventable, there were 1,202 alcohol and 1,054 habit-forming drug deaths in the state during 2013. The average age of death for these substance-related deaths was mid-50s.

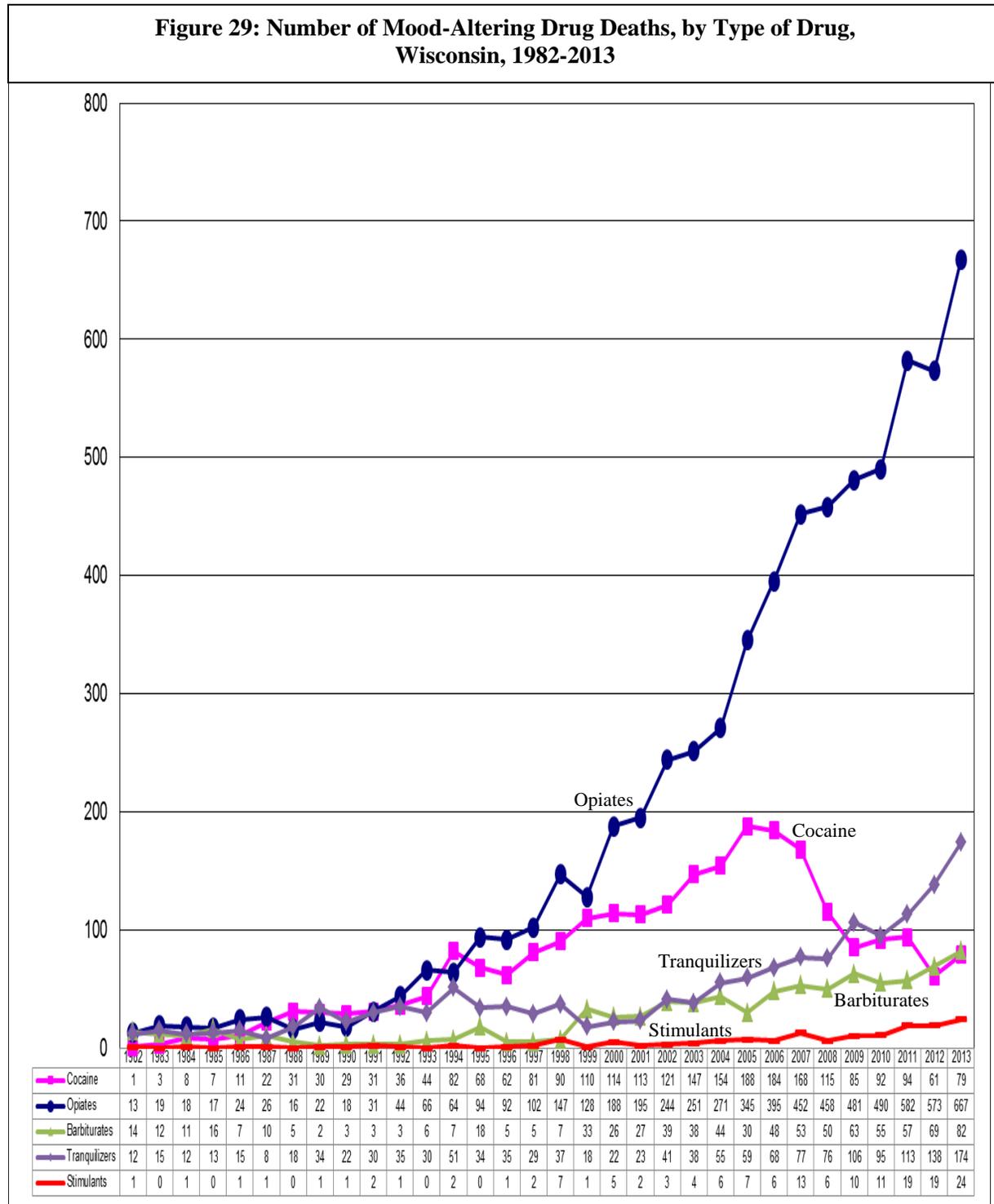
Figure 28: Alcohol and Mood-Altering Drug Deaths, Wisconsin, 1970-2013



Data Source: Death Certificates, Office of Health Informatics, WI Department of Health Services

Mood-Altering, Habit-Forming Drug Deaths

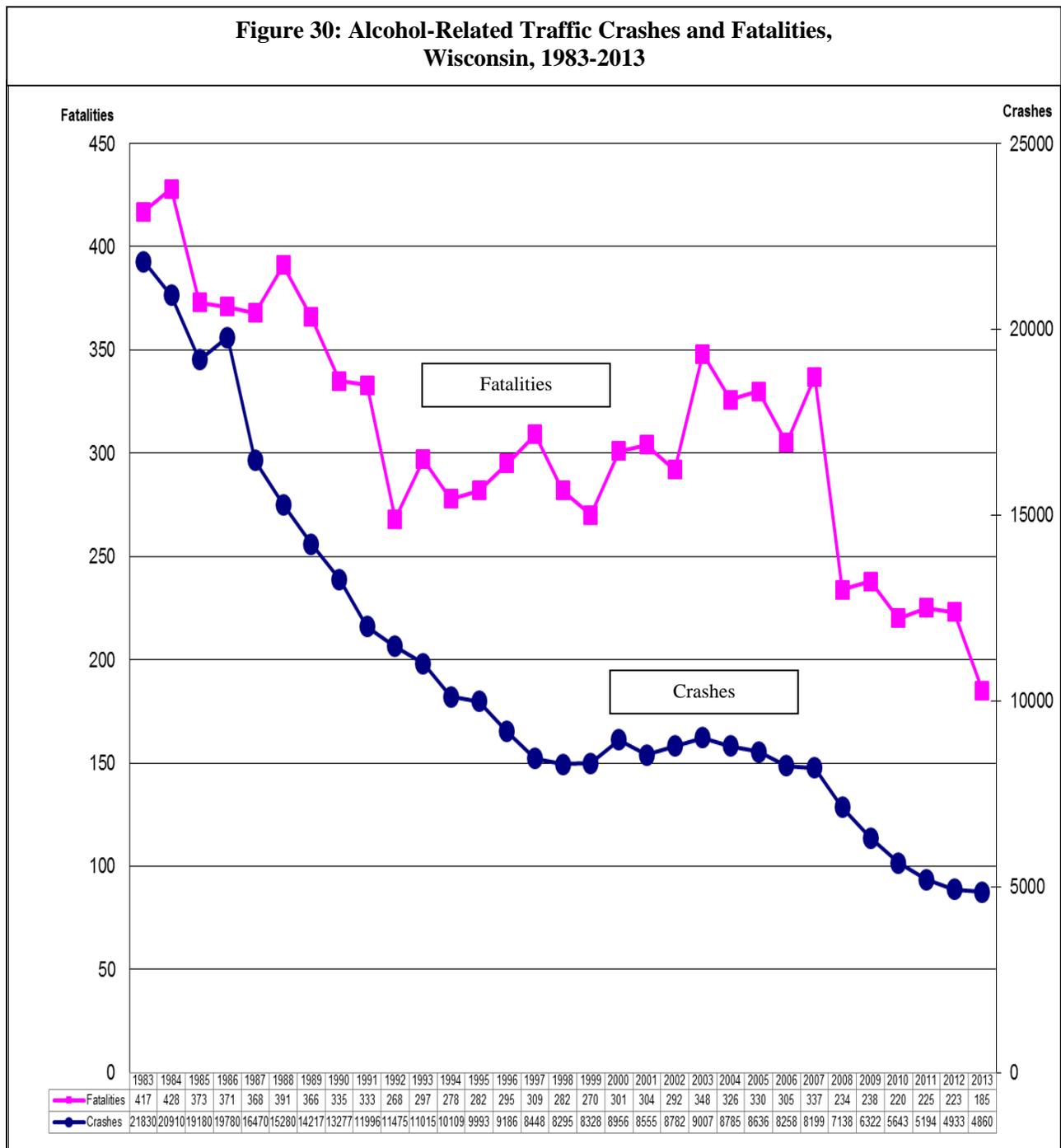
The chart below breaks out the deaths related to various individual habit-forming illicit drugs and medications. Opiate deaths in Wisconsin increased over 45% in the past 5 years, from 458 in 2008 to 667 in 2013.



Data Source: Death Certificates, Office of Health Informatics, WI Department of Health Services

Alcohol-Related Traffic Crashes and Fatalities

Many alcohol-related traffic fatalities are not counted in the previous death data and so a separate graph displaying these public safety deaths is provided. Public safety policy, law enforcement and substance abuse, prevention, intervention and treatment efforts continue to drive alcohol-related traffic crashes, injuries and deaths down. There were 4,860 alcohol-related traffic crashes and 185 alcohol-related traffic deaths across Wisconsin in 2013, down from 21,830 and 417 respectively, in 1983.

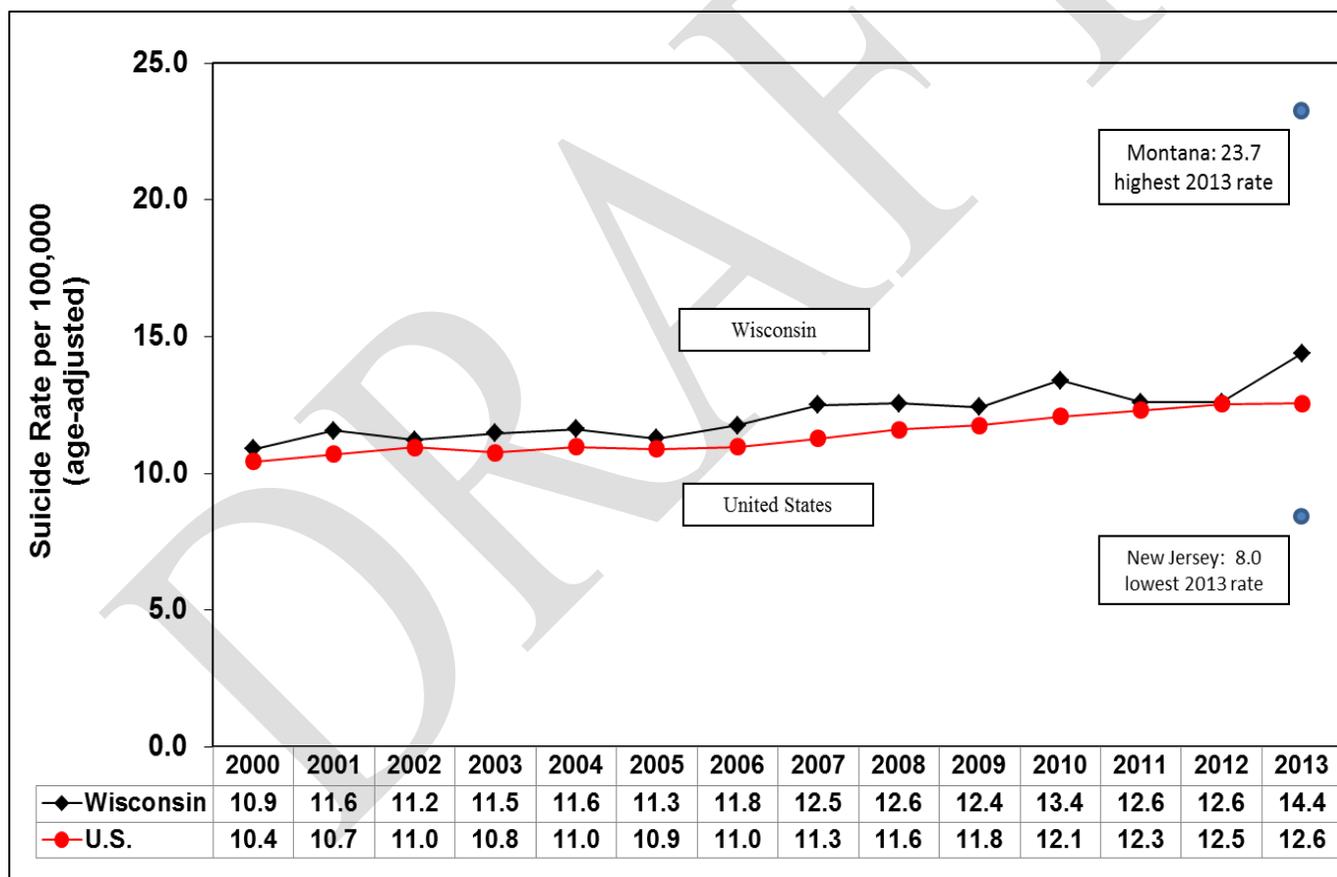


Data Source: WI Department of Transportation

Suicide Rates

Over the last 14-year period from 2000-2013, the national suicide rate in the United States has steadily risen from 10.4 to 12.6 per 100,000 in the population. Over the same period, the Wisconsin suicide rate has risen from 10.9 to 14.4 per 100,000 people. From 1999-2005, the Wisconsin suicide rate did not change, but from 2005-2013 the suicide rate increased by three people per 100,000 from 11.3 to 14.4 with a one point increase occurring in 2010 and more recently in 2013. The national rate has consistently been below Wisconsin's rate by about one person per 100,000 or less. The state rates are more variable than the national rate, but the large increase to 14.4 in 2013 in Wisconsin will need to be monitored closely to determine if it is an ongoing trend. While Wisconsin's rate is much lower than Montana's rate which leads the U.S. in 2013 at 23.7, a future target for Wisconsin could be New Jersey's rate which was the lowest in 2013 at 8.0.

Figure 31: Wisconsin and U.S. Suicide Rates 2000-2013

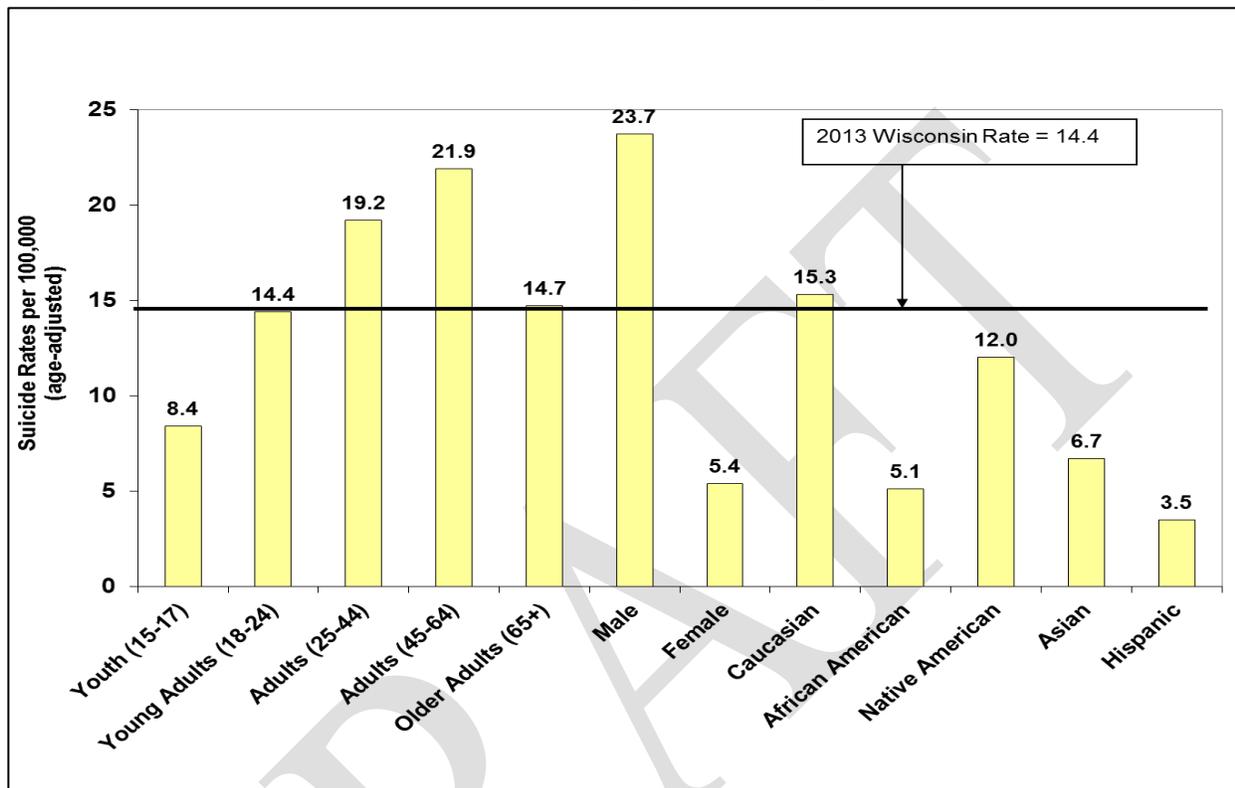


Data Source: CDC/NCHS; Wisconsin Interactive Statistics on Health (WISH).

Relative to other demographic groups, the highest suicide rate in Wisconsin in 2013 was for males at 23.7 per 100,000 people. The rise in the overall Wisconsin rate from 2012-2013 was driven by males as the female suicide rate did not increase over that same period. Similar to the 2011 Wisconsin suicide rates in the original Needs Assessment report, individuals in the 45-64 age range have the highest suicide rate which is more than twice the rate of youth suicides. For racial and ethnic groups in Wisconsin, the rate for Caucasians is higher than for other individuals

with minority racial backgrounds. The numbers of suicides in non-Caucasian groups is often too small to show reliable trends as illustrated by the rate for Asians which was 20.2 in 2010 and 6.7 in 2013.

Figure 32: Suicide Rates for Wisconsin Demographic Groups, 2013



Data Source: CDC/NCHS; Wisconsin Interactive Statistics on Health (WISH).

Mental Health Inpatient Hospital Readmission Rates

Unplanned hospital readmissions can be an indicator of poor quality mental health care. Thirty-day hospital readmissions are listed as a quality measure for the Patient Protection and Affordable Care Act (PPACA), the U.S. Department of Health and Human Services (HHS), and Centers for Medicare and Medicaid Services (CMS). It has become a common evaluation measure because unplanned readmissions are costly and generally indicates that the mental health system failed to properly address the consumer’s acute condition.

Multiple factors may contribute to the risk of psychiatric hospital inpatient readmissions. The severity of a consumer’s mental health and/or substance abuse needs are typically important factors, but agency processes also can influence the likelihood of a consumer’s readmission to an inpatient hospital. Poor medication adherence management, poor patient education, and deficient outpatient follow-up after discharge from inpatient care can increase the likelihood of a readmission. The Wisconsin DHS has been working with select counties since 2010 to reduce readmission rates through the use of quality improvement techniques to improve these agency processes.

Table 20 below describes the 30-day readmission inpatient hospital rates for mental health consumers served in the county mental health system from State Fiscal Year (SFY) 2009-2013. The readmission rate has been declining in Wisconsin over the last five years from 9.7% to 7.7%. Another positive indicator of Wisconsin's performance in this area is that the average 30-day mental health inpatient readmission rate for 25 other states reported to SAMHSA is significantly higher at 13.4%. Readmission rates are inconsistent across counties, however. While incomplete data reporting by some counties has been documented to contribute to the variation in readmission rates, the variation is also a likely indicator that there is the potential for more improvement in certain areas of the state on this acute indicator.

Table 20: Mental Health Inpatient 30-Day Readmission Rates, by County/Region, SFY 2009-2013

County/Region	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Adams	4.4%	10.1%	12.8%	3.9%	5.9%
Ashland	9.1%	0.0%	0.0%	11.1%	0.0%
Barron	5.6%	2.4%	4.1%	4.7%	7.1%
Bayfield	0.0%	4.3%	3.3%	7.3%	0.0%
Brown	13.7%	13.3%	11.6%	9.9%	11.6%
Buffalo	0.0%	16.7%	0.0%	0.0%	0.0%
Burnett	5.0%	5.0%	10.0%	0.0%	0.0%
Calumet	2.0%	4.0%	3.5%	3.0%	3.6%
Chippewa	6.5%	2.7%	8.0%	0.0%	4.5%
Clark	3.7%	1.7%	5.7%	5.3%	8.8%
Columbia	7.5%	7.6%	3.1%	5.1%	5.1%
Crawford	0.0%	21.9%	7.1%	9.5%	10.0%
Dane	10.0%	6.1%	10.9%	11.1%	9.4%
Dodge	12.5%	8.2%	6.9%	6.4%	5.2%
Door	0.0%	22.7%	10.3%	8.6%	5.6%
Douglas	0.0%	7.1%	0.0%	0.0%	0.0%
Dunn	7.4%	8.3%	6.3%	14.3%	16.7%
Eau Claire	3.3%	0.0%	0.0%	0.0%	0.0%
Florence	0.0%	0.0%	0.0%	0.0%	0.0%
Fond du Lac	9.3%	4.0%	5.7%	6.8%	9.7%
Forest/Oneida/Vilas	7.7%	6.6%	6.5%	5.7%	4.3%
Grant and Iowa	8.0%	10.2%	6.1%	5.2%	2.3%
Green	2.7%	5.5%	5.9%	4.3%	0.0%
Green Lake	5.9%	4.2%	0.0%	3.4%	8.7%
Iron	11.1%	0.0%	0.0%	20.0%	0.0%
Jackson	4.3%	10.0%	10.0%	0.0%	6.7%
Jefferson	10.8%	11.5%	6.2%	11.3%	5.9%
Juneau	6.2%	0.0%	0.0%	0.0%	0.0%
Kenosha	10.5%	8.0%	3.1%	4.3%	8.5%
Kewaunee	7.7%	12.5%	16.7%	0.0%	27.3%
La Crosse	4.5%	3.9%	3.1%	6.3%	2.3%

County/Region	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Lafayette	5.7%	11.8%	4.8%	13.3%	14.3%
Lincoln/Langlade/Marathon	1.2%	3.0%	11.8%	1.2%	2.8%
Manitowoc	13.5%	9.2%	9.0%	5.8%	3.8%
Marinette	8.1%	5.7%	0.0%	6.1%	10.9%
Marquette	3.6%	5.6%	0.0%	0.0%	13.0%
Menominee	2.8%	0.0%	4.7%	9.1%	5.9%
Milwaukee	13.9%	13.4%	12.3%	11.2%	12.4%
Monroe	7.8%	4.2%	2.9%	0.0%	7.3%
Oconto	6.1%	5.0%	10.0%	7.7%	9.1%
Outagamie	7.0%	3.7%	6.9%	5.0%	6.9%
Ozaukee	0.0%	0.0%	28.6%	0.0%	13.6%
Pepin	0.0%	0.0%	0.0%	0.0%	0.0%
Pierce	2.4%	3.2%	0.0%	0.0%	0.0%
Polk	7.9%	3.5%	2.4%	9.0%	2.9%
Portage	4.1%	6.5%	1.8%	7.3%	16.7%
Price	12.5%	3.6%	4.5%	12.0%	6.3%
Racine	8.9%	8.6%	4.8%	9.5%	6.7%
Richland	22.9%	13.0%	27.3%	0.0%	0.0%
Rock	6.7%	8.4%	8.9%	6.8%	2.4%
Rusk	0.0%	0.0%	0.0%	22.2%	20.0%
Sauk	4.2%	9.0%	11.7%	6.3%	2.8%
Sawyer	0.0%	0.0%	6.3%	3.3%	1.1%
Shawano	5.0%	5.2%	6.7%	5.5%	0.0%
Sheboygan	13.7%	9.0%	11.6%	14.1%	9.4%
St Croix	9.1%	5.5%	5.6%	5.3%	1.4%
Taylor	3.6%	6.9%	20.8%	9.5%	0.0%
Trempealeau	6.5%	10.5%	17.6%	6.7%	11.8%
Vernon	0.0%	0.0%	0.0%	9.5%	0.0%
Walworth	5.1%	5.5%	13.5%	3.5%	7.2%
Washburn	0.0%	12.5%	0.0%	9.1%	0.0%
Washington	6.9%	7.5%	9.9%	4.5%	7.0%
Waukesha	8.0%	5.9%	6.9%	6.1%	6.2%
Waupaca	7.9%	3.9%	6.1%	6.0%	3.4%
Waushara	18.4%	6.1%	5.6%	7.9%	3.1%
Winnebago	6.1%	9.1%	8.4%	10.9%	7.9%
Wood	10.3%	11.2%	12.0%	7.9%	8.7%
Statewide Totals	9.7%	9.1%	9.4%	8.1%	7.7%

Data Source: Human Services Reporting System (HSRS) and Program Participation System (PPS), WI Department of Health Services; Mental Health Institute Insight System.

BY-LAWS
of the
State of Wisconsin
State Council on Alcohol and Other Drug Abuse
As Approved
June 6, 2008
Amended 9-10-10, 9-9-11, 12-13-13, 12-12-14

<please note: lines underlined below are taken directly from statute.>

ARTICLE I

Purpose and Responsibilities

Section 1. Authority

The council is created in the office of the governor pursuant to sec. 14.017 (2), Wis. Stats. Its responsibilities are specified under sec. 14.24, Wis. Stats.

Section 2. Purpose

The purpose of the state council on alcohol and other drug abuse is to enhance the quality of life of Wisconsin citizens by preventing alcohol, tobacco and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities by:

- a. Supporting, promoting and encouraging the implementation of a system of alcohol, tobacco and other drug abuse services that are evidence-based, gender and culturally competent, population specific, and that ensure equal and barrier-free access;
- b. Supporting the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with a special emphasis on underage use; and
- c. Supporting and encouraging recovery in communities by reducing discrimination, barriers and promoting healthy lifestyles.

Section 3. Responsibilities

The state council on alcohol and other drug abuse shall:

- a. Provide leadership and coordination regarding alcohol and other drug abuse issues confronting the state.

- b. Meet at least once every 3 months.
- c. By June 30, 1994, and by June 30 every 4 years thereafter, develop a comprehensive state plan for alcohol and other drug abuse programs. The state plan shall include all of the following:
 - i. Goals, for the time period covered by the plan, for the state alcohol and other drug abuse services system.
 - ii. To achieve the goals in [par. \(a\)](#), a delineation of objectives, which the council shall review annually and, if necessary, revise.
 - iii. An analysis of how currently existing alcohol and other drug abuse programs will further the goals and objectives of the state plan and which programs should be created, revised or eliminated to achieve the goals and objectives of the state plan.
- d. Each biennium, after introduction into the legislature but prior to passage of the biennial state budget bill, review and make recommendations to the governor, the legislature and state agencies, as defined in [s. 20.001 \(1\)](#), regarding the plans, budgets and operations of all state alcohol and other drug abuse programs. The council also recommends legislation, and provides input on state alcohol, tobacco and other drug abuse budget initiatives.
- e. Provide the legislature with a considered opinion under [s. 13.098](#).
- f. Coordinate and review efforts and expenditures by state agencies to prevent and control alcohol and other drug abuse and make recommendations to the agencies that are consistent with policy priorities established in the state plan developed under [sub. \(3\)](#).
- g. Clarify responsibility among state agencies for various alcohol and other drug abuse prevention and control programs, and direct cooperation between state agencies.
- h. Each biennium, select alcohol and other drug abuse programs to be evaluated for their effectiveness, direct agencies to complete the evaluations, review and comment on the proposed evaluations and analyze the results for incorporation into new or improved alcohol and other drug abuse programming.

- i. Publicize the problems associated with abuse of alcohol and other drugs and the efforts to prevent and control the abuse. Issue reports to educate people about the dangers of alcohol, tobacco and other drug abuse.
- j. Form committees and sub-committees for consideration of policies or programs, including but not limited to, legislation, funding and standards of care, for persons of all ages, ethnicities, sexual orientation, disabilities, and religions to address alcohol, tobacco and other drug abuse problems.

ARTICLE II

Membership

Section 1. Authority

Membership is in accordance with section 14.017(2), Wis. Stats.

Section 2. Members

- 2.1** The 22-member council includes six members with a professional, research or personal interest in alcohol, tobacco and other drug abuse problems, appointed for four-year terms, and one of them must be a consumer representing the public. It was created by chapter 384, laws of 1969, as the drug abuse control commission. Chapter 219, laws of 1971, changed its name to the council on drug abuse and placed the council in the executive office. It was renamed the council on alcohol and other drug abuse by chapter 370, laws of 1975, and the state council on alcohol and other drug abuse by chapter 221, laws of 1979. In 1993, Act 210 created the state council on alcohol and other drug abuse, incorporating the citizen's council on alcohol and other drug abuse, and expanding the state council and other drug abuse's membership and duties. The state council on alcohol and other drug abuse's appointments, composition and duties are prescribed in sections 15.09 (1)(a), 14.017 (2), and 14.24 of the statutes, respectively.

The council strives to have statewide geographic representation, which includes urban and rural populated areas, to have representation from varied stakeholder groups, and shall be a diverse group with respect to age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

2.2 There is created in the office of the governor a state council on alcohol and other drug abuse consisting of the governor, the attorney general, the state superintendent of public instruction, the secretary of health services, the commissioner of insurance, the secretary of corrections, the secretary of transportation and the chairperson of the pharmacy examining board, or their designees; a representative of the controlled substances board; a representative of any governor's committee or commission created under [subch. I](#) of ch. 14 to study law enforcement issues; 6 members, one of whom is a consumer representing the public at large, with demonstrated professional, research or personal interest in alcohol and other drug abuse problems, appointed for 4-year terms; a representative of an organization or agency which is a direct provider of services to alcoholics and other drug abusers; a member of the Wisconsin County Human Service Association, Inc., who is nominated by that association; and 2 members of each house of the legislature, representing the majority party and the minority party in each house, chosen as are the members of standing committees in their respective houses. [Section 15.09](#) applies to the council.

2.3 Selection of Members

From Wis. Stats. 15.09 (1)(a); Unless otherwise provided by law, the governor shall appoint the members of councils for terms prescribed by law. Except as provided in [par. \(b\)](#), fixed terms shall expire on July 1 and shall, if the term is for an even number of years, expire in an odd-numbered year.

2.4 Ex-Officio Members

- a. Ex-officio members may be appointed by a majority vote of the council to serve on the council, special task forces, technical subcommittees and standing committees. Other agencies may be included but the following agencies shall be represented through ex-officio membership: The Wisconsin Departments of: Revenue, Work Force Development, Safety and Professional Services, Veteran Affairs and Children and Families, the Wisconsin Technical Colleges System and the University of Wisconsin System.
- b. Ex-officio members of the council may participate in the discussions of the council, special task forces, technical subcommittees, and standing committees except that the chairperson may limit their participation as necessary to allow full participation by appointed members of the council subject to the appeal of the ruling of the chairperson.

- c. An ex-officio member shall be allowed to sit with the council and participate in discussions of agenda items, but shall not be allowed to vote on any matter coming before the council or any committee of the council, or to make any motion regarding any matter before the council.
- d. An ex-officio member may not be elected as an officer of the council.
- e. An ex-officio member shall observe all rules, regulations and policies applicable to statutory members of the council, and any other conditions, restrictions or requirements established or directed by vote of a majority of the statutory members of the council

2.5 Selection of Officers

Unless otherwise provided by law, at its first meeting in each year the council shall elect a chairperson, vice-chairperson and secretary from among its members. Any officer may be reelected for successive terms. For any council created under the general authority of s. 15.04 (1) (c), the constitutional officer or secretary heading the department or the chief executive officer of the independent agency in which such council is created shall designate an employee of the department or independent agency to serve as secretary of the council and to be a voting member thereof.

2.6 Terms of Voting Members

- a. Voting members shall remain on the council until the effective date of their resignation, term limit or removal by the governor, or until their successors are named and appointed by the governor.
- b. Letter of resignation shall be sent to the governor and council chairperson.
- c. Each voting member or designee of the council is entitled to one vote.

2.7 Code of Ethics

All members of the council are bound by the codes of ethics for public officials, Chapter 19, Wis. Stats., except that they are not required to file a statement of economic interest. Ex-officio members are not required to file an oath of office. As soon as reasonably possible after appointment or commencement of a conflicting interest and before

voting on any grant, members shall reveal any actual or potential conflict of interest. Chapter 19.46 of Wisconsin State Statutes states that no state public official may take any official action substantially affecting a matter in which the official, a member of his or her immediate family, or an organization with which the official is associated has a substantial financial interest or use his or her office or position in a way that produces or assists in the production of a substantial benefit, direct or indirect, for the official, one or more members of the official's immediate family either separately or together, or an organization with which the official is associated.

2.8 Nondiscrimination

The council will not discriminate because of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

2.9 Nomination Process for Appointed Members and Officers

As per Article II, Section 2.1, the governor is required to appoint six citizen members. In addition, the council elects the chairperson, vice-chairperson and secretary, annually. The council will follow this process when making recommendations to the governor concerning appointments and nominating a slate of officers:

- a. The council, along with the office of the governor and department staff, will monitor when council terms will expire. It will also monitor the composition of the council with respect to the factors specified in Article II, Section 2.1.
- b. The vice-chairperson of the council shall convene a nominating committee and appoint a chairperson of that committee as needed to coordinate the process for all appointments to the council as outlined in Article II, Section 2 and annually put forth a slate of officers as identified in Article II Sections 3.1, 3.2 and 3.3. The Council Chairperson may ask for nominations from the floor to bring forth nominations in addition to the slate of officers brought forth by the nominating committee. The nominating committee shall make recommendations to the council regarding nominations and appointments prior to the September council meeting and have such other duties as assigned by the council.
- c. The nominating committee of the council, with support of bureau staff, will publicize upcoming vacancies, ensuring that publicity includes interested and underrepresented groups, including

alcohol, tobacco and other drug abuse agencies, alcohol, tobacco and other drug abuse stakeholder groups, consumers, and providers of all ethnic groups. Publicity materials will clearly state that council appointments are made by the governor. Materials will also state that the governor normally considers the council's recommendations in making council appointments.

- d. While any person may apply directly to the governor according to the procedures of that office, all applicants will be asked to provide application materials to the council as well. Bureau staff will make contact with the office of the governor as necessary to keep the committee informed regarding applicants, including those that may have failed to inform the committee of their application.
- e. Applicants shall provide a letter of interest or cover letter, along with a resume and any other materials requested by the office of the governor. The nominating committee, in consultation with department staff, may request additional materials. The nominating committee, with support of bureau staff, will collect application materials from nominees, including nominees applying directly to the governor. The nominating committee or staff will acknowledge each application, advising the applicant regarding any missing materials requested by the nominating committee. The nominating committee or staff will review each application to ensure that all required nomination papers have been completed.
- f. The nominating committee may establish questions to identify barriers to attendance and other factors related to ability to perform the function of a member of the state council on alcohol and other drug abuse and to identify any accommodations necessary to overcome potential barriers to full participation by applicants. The nominating committee may interview applicants or designate members and/or staff to call applicants. Each applicant shall be asked the standard questions established by the committee.
- g. The nominating committee shall report to the full council regarding its review of application materials and interviews. The report shall include the full roster of applicants as well as the committee's recommendations for appointment.
- h. The council shall promptly act upon the report of the nominating committee. Council action shall be in the form of its recommendation to the governor. Department staff shall convey the council's recommendation to the office of the governor.

2.10 Removal from Office

The Governor may remove appointed members from the council. The council may recommend removal but the Governor makes the final decision regarding removal.

Section 3. Officers

3.1 Chairperson

The chairperson is the presiding officer and is responsible for carrying out the council's business including that motions passed be acted upon in an orderly and expeditious manner and assuring that the rights of the members are recognized. The chairperson may appoint a designee to preside at a meeting if the vice-chairperson is unable to preside in their absence. The chairperson is also responsible for organizing the work of the council through its committee structure, scheduling council meetings and setting the agenda. The chairperson may serve as an ex-officio member of each council committee. The chairperson shall represent the positions of the council before the legislature, governor and other public and private organizations, unless such responsibilities are specifically delegated to others by the council or chairperson. The agenda is the responsibility of the chairperson, who may consult with the executive committee or other council members as necessary.

3.2 Vice-Chairperson

The vice-chairperson shall preside in the absence of the chairperson and shall automatically succeed to the chair should it become vacant through resignation or removal of the chairperson until a new chairperson is elected. The vice-chairperson shall also serve as the council representative on the governor's committee for people with disabilities (GCPD). If unable to attend GCPD meetings, the vice-chairperson's designee shall represent the council.

3.3 Secretary

The secretary is a member of the executive Committee as per Article IV, Section 5. The secretary is also responsible for carrying out the functions related to attendance requirements as per Article III, Section 6.

3.4 Vacancies

In the event a vacancy occurs among the Officers (Chairperson, Vice-Chairperson, or Secretary) of the State Council on Alcohol and Other

Drug Abuse, the following procedure should be followed: In the event of a vacancy of the Chairperson, the Vice-Chairperson assumes the responsibility of Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Vice-Chairperson, the Secretary assumes the responsibility of the Vice-Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Secretary, the Chairperson shall appoint a replacement from the statutory membership until such time as new Officers are elected according to the procedures outlined in the By-Laws.

ARTICLE III

Council Meetings

Section 1. Council Year

The council year shall begin at the same time as the state fiscal year, July 1.

Section 2. Meetings

2.1 Regular and special meetings

Regular meetings shall be held at least four times per year at dates and times to be determined by the council. Special meetings may be called by the chairperson or shall be called by the chairperson upon the written request of three members of the council.

2.3 Notice of meetings

The council chairperson shall give a minimum of seven days written notice for all council meetings. An agenda shall accompany all meeting notices. Public notice shall be given in advance of all meetings as required by Wisconsin's Open Meetings Law. If a meeting date is changed, sufficient notice shall be given to the public.

2.3 Quorum

A simple majority (51%) of the membership qualified to vote shall constitute a quorum to transact business.

Section 3. Public Participation

Consistent with the Wisconsin Open Meetings law, meetings are open and accessible to the public.

Section 4. Conduct of Meetings

- 4.1 Meetings shall be conducted in accordance with the latest revision of Robert's Rules of Order, unless they are contrary to council by-laws or federal or state statutes, policies or procedures.

Section 5. Agendas

- 5.1 Agendas shall include approval of minutes from prior meetings, any action items recommended by a committee, an opportunity for public comment, and other appropriate matters.
- 5.2 Requests for items to be included on the agenda shall be submitted to the chairperson two weeks prior to the meeting.

Section 6. Attendance Requirements

- 6.1 All council members and committee members are expected to attend all meetings of the council or the respective committees. Attendance means presence in the room for more than half of the meeting.
- 6.2 Council or committee members who are sick, hospitalized or who have some other important reason for not attending should notify the secretary or the secretary's designee or committee staff person or chairperson at least a week before the meeting. If that is not possible, notice should be given as soon as possible.
- 6.3 Any statutory members or designees ~~member~~ of the council or committee who has two unexcused absences from meetings within any twelve month period will be contacted by the secretary of the council or committee chair to discuss the reasons for absence and whether the member will be able to continue serving. Appointed members who do not believe that they can continue should tender their resignation in writing to the secretary of the council or committee chair. Any council member resignations will be announced by the chairperson and forwarded by written notice to the Governor of the need for a new appointment. The replacement member would fulfill he resigned member's term.

Section 7. Staff Services

The division of mental health and substance abuse services shall provide staff services. Staff services shall include: record of attendance and prepare minutes of meetings; prepare draft agendas; arrange meeting rooms; prepare correspondence for signature of the

chairperson; offer information and assistance to council committees; analyze pending legislation and current policy and program issues; prepare special reports, and other materials pertinent to council business.

Section 8. Reimbursement of Council and Committee Members

According to Section 15.09 of Wisconsin Statutes: Members of a council shall not be compensated for their services, but, except as otherwise provided in this subsection, members of councils created by statute shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties, such reimbursement in the case of an elective or appointive officer or employee of this state who represents an agency as a member of a council to be paid by the agency which pays his or her salary.

ARTICLE IV

Committees

Section 1. Committee Structure

- 1.1** There shall be an executive committee as provided below. The executive committee is a standing committee of the council.

- 1.2** The council may establish other standing committees and subcommittees as necessary or convenient to conduct its business. Of the standing committees established by the state council on alcohol and other drug abuse, at least one shall have a focus on issues related to the prevention of alcohol, tobacco and other drug abuse, at least one shall have a focus on issues related to cultural diversity, at least one shall have a focus on issues related to the intervention and treatment of alcohol, tobacco and other drug abuse, and at least one shall have a focus on issues related to the planning and funding of alcohol and other drug abuse services. Subcommittees are a subset of a standing committee. Subcommittees are standing committees, which by another name is a permanent committee. Standing committees meet on a regular or irregular basis dependent upon their enabling act, and retain any power or oversight claims originally given them until subsequent official actions of the council (changes to law or by-laws) disbands the committee. Of the standing subcommittees established by the state council on alcohol and other drug abuse, at least one shall have a focus on children youth and families and is a subcommittee of the intervention and treatment committee, at least one shall have a focus on cultural competency and is a subcommittee of the cultural diversity committee, and at least one shall have a focus on epidemiology and is a subcommittee of the prevention committee.

Ad-hoc committees are established to accomplish a particular task and are to be temporary, with the charge being well-defined and linked to SCAODA's strategic plan, not to exceed duration of twelve calendar months. Ad-hoc committees are formed by standing committee chairs. Ad-hoc committees must report their progress at the meeting of their standing committee. Ad-hoc committees can be granted extensions by the standing committee chair.

It is the intent of this section that:

- There should be periodic review of the structure and progress of the work of the committees, subcommittees and ad-hoc committees.
- If the officers have concerns about the work of the standing committees, subcommittees or ad-hoc committees, they could convene an executive committee meeting to discuss options, "for the good of the order."
- The intent of this group is to recommend that ad-hoc committees be time-limited (recommend one year) and the committee chair determines if the work should go forward beyond the original charge.
- The charge should be well-defined and linked to SCAODA's strategic plan.
- The committee chairs should be primarily responsible for creating and disbanding ad-hoc groups.
- The committee chairs should be responsible for monitoring the work and duration of the work in coordination with SCAODA.

1.3 Committees may determine their own schedules subject to direction from the full council.

Section 2. Composition of Committees

2.1 Council committees may include members of the public as well as council members.

2.2 The council chairperson may appoint a chairperson who must be a member of the council, for each committee. The council chairperson, with the advice of the committee chairperson may appoint other committee members.

2.3 Committees may designate subcommittees including ad hoc committees, as necessary or convenient subject to limitation by the full council.

2.4 A council member shall not chair more than one committee.

- 2.5** A committee chairperson's term shall not exceed the length of their appointment or four years whichever comes first. With the majority vote of the council, a chairperson may be reappointed.

Section 3. Requirements for all Committees

- 3.1** A motion or resolution creating a committee shall designate the mission and duties of the committee. The council may also specify considerations for the chairperson to follow in appointing committee chairpersons and members and such other matters as appropriate.
- 3.2** All committee members are expected to attend all meetings of the committee. Attendance means presence in the room for more than half of the meeting.
- 3.3** Any committee may authorize participation by telephone conference or similar medium that allows for simultaneous communication between members as permitted by law.
- 3.4** Committee members who are sick, hospitalized or who have some other important reason for not attending should notify the chairperson or the chairperson's designee at least a week before the meeting. If that is not possible, notice should be given as soon as possible.
- 3.5** Any committee member who has two unexcused absences within a twelve month period will be contacted by the committee chairperson to discuss the reasons for absence and whether the member will be able to continue serving. Members who do not believe that they can continue should tender their resignation in writing to the committee chairperson. Any resignations will be announced to the council chairperson and to the committee.
- 3.6** The committee chairperson may remove committee members, other than executive committee members, after notice of proposed removal to and an opportunity to be heard by the member consistently with this process.

Section 4. Requirements for Committee Chairpersons

The chairperson of each committee is responsible for:

- a. Ensuring that the by-laws and every applicable directive of the council are followed by the committee as indicated in Chapters 15.09, 14.017 and 14.24 of Wisconsin Statutes;
- b. Ensuring that recommendations of the committee are conveyed to the full council;

- c. Submitting meeting minutes in the approved format to the council; and
- d. Coordinating work with other committees where items could be of mutual interest.

Section 5. Executive Committee

5.1 The executive committee shall be comprised of at least three members, including the council chairperson, vice-chairperson and secretary.

5.2 The executive committee will have the following responsibilities:

- a. Provide policy direction to and periodically evaluate the performance of the council and its activities relating to direction from the division of mental health and substance abuse services.
- b. Meet at the request of the chairperson as needed;
- c. Provide for an annual review of the by-laws;
- d. Act on behalf of the council when a rapid response is required, provided that any such action is reported to the council at its next meeting for discussion and ratification; and
- e. Other duties designated by the council.

5.3 Rapid Response

The executive committee may act on behalf of the full council only under the following circumstances:

- a. When specifically authorized by the council;
- b. When action is needed to implement a position already taken by the council;
- c. Except when limited by the council, the executive committee may act upon the recommendation of a committee, other than the executive committee, if such action is necessary before a council meeting may reasonably be convened, provided that if more than one committee has made differing recommendations concerning the subject, the executive committee may not act except to request further study of the subject; or
- d. Except when limited by the council, the executive committee, by unanimous consent, may take such other action as it deems

necessary before a council meeting may reasonably be convened.

ARTICLE V

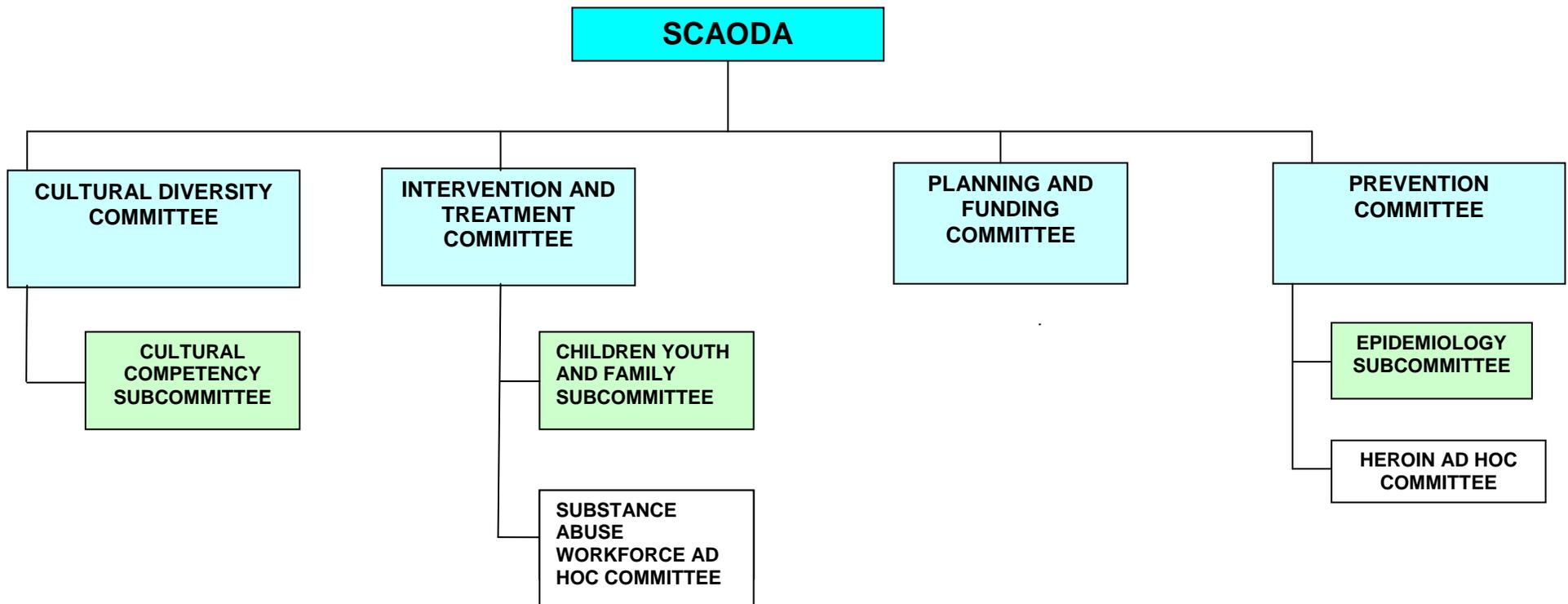
Amendments

The by-laws may be amended, or new by-laws adopted, after thirty days written notice to council members by a two-thirds vote of the full council membership present at a regularly scheduled meeting.

SCAODA Organization Chart

June 2014

1. Cultural Diversity Committee
 - a. Cultural Competency Subcommittee
2. Intervention and Treatment Committee
 - a. Children Youth and Family Subcommittee
3. Planning and Funding Committee
4. Prevention / SPF-SIG Advisory Committee
 - a. Epidemiology Subcommittee



Functions

