Wisconsin FFY 2014 – 2015

Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application (DRAFT)

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

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SECTION 1:
State Information

Section will contain:

1. **State Information**
2. **Assurance – Non-Construction Programs**
3. **Certifications**
4. **Chief Executive Officer's Funding Agreements/Certification (Form 3) [SA]**
5. **Chief Executive Officer's Funding Agreements/Certification (Form 3) [MH]**
6. **Disclosure of Lobbying Activities**

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SECTION 2:
Planning Steps

Section contents:

1. **Planning Step 1 - Assess the strengths and needs of the service system to address the specific population.**
2. **Planning Step 2 – Identify the unmet service needs and critical gaps within the current system.**
3. **Priority Areas and Annual Performance Indicators (Table 1)**

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

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

Wisconsin has a state-supervised, county-based system of mental health and substance abuse (MH/SA) system. The Division of Mental Health and Substance Abuse Services (DMHSAS) in the Department of Health Services (DHS) is the state MH/SA agency and is the designated State Mental Health Authority (SMHA) and Single State Agency (SSA) for Substance Abuse. The division is responsible for allocating state and federal funding for the provision of MH/SA services and for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, more commonly referred to as state administrative code Chapter 51. While the state has broad responsibility for MH/SA system planning, management and oversight, it is the state's 72 counties that are statutorily responsible for administering MH/SA services.

Wisconsin statutes further provide for counties to meet MH/SA service responsibility through single county systems, such as single county boards and departments of community programs or human services, or through multi-county systems. Presently the state mental health system is organized into 67 regions or counties that provide care and supervision of mental health services at the local level for all of Wisconsin's 72 counties.

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

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

Wisconsin's Mental Health and Substance Abuse System

Mental Health Services

As noted above, county mental health providers use county tax levy dollars to fund a portion of the services they deliver. State and federal tax dollars are also used to fund a portion of mental health

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

Psychiatric Hospitalization

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

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

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

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

Substance Abuse Prevention and Treatment Services

Wisconsin maintains a continuum of substance abuse prevention and treatment services. The DMHSAS within the Wisconsin DHS has several mechanisms in place to ensure that substance abuse services are effective and efficient. As with mental health services, Wisconsin operates under a State-supervised,

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

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

Under Wisconsin Statute 51.42, county governments have the responsibility to develop and manage a system of care for persons with substance use disorders. This includes the preparation of a local short- and long-range plan to address substance abuse treatment needs, maintain oversight of the planning process, and maintain an inventory of existing resources. These county agencies are required to report the National Outcomes Measures (NOMS) data, both prevention and treatment data, through Wisconsin's Human Services Reporting System (HSRS which populates TEDS) and SAP-SIS (Substance Abuse Prevention Service Information System) which are used for accountability purposes. The reporting of both the prevention and treatment NOMS are a contractual requirement with providers. Direct grants awarded from the State to private, non-profit and county agencies are also subject to performance management. Direct grant agencies are required to set performance objectives and report on progress on a semi-annual basis. DMHSAS contract administrators review these semi-annual reports and use the information to provide technical assistance and make contractual modifications as needed. Contract administrators also perform annual site visits to provider agencies to ensure programmatic compliance and offer technical assistance as necessary

Substance Abuse Service Modalities

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

Special Substance Abuse Service Programs

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

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

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

Since its enactment by the Legislature in 1982, the partnership of the DHS, Department of Transportation (DOT), county agencies, law enforcement, vocational and technical schools, and local treatment centers, has reduced alcohol-related traffic crashes, injuries and deaths. County designated Intoxicated Driver Program (IDP) assessment agencies are responsible for assessing Wisconsin drivers convicted of operating while intoxicated (OWI). Assessors use a Wisconsin-specific IDP assessment (Wisconsin Assessment of the Intoxicated Driver - WAID) to determine whether drivers need education, treatment or both. Approximately 30,000 adjudicated intoxicated drivers received assessments of their alcohol and other drug use under this program. Of these, one-half receive substance abuse treatment services from community programs. Data reported by the DOT show that 76 percent of convicted drivers complete their treatment-oriented driver safety plans and 86 percent do not re-offend during the five years following their arrest. The IDP is one of the Department's most successful programs of intervention and treatment for substance use disorders.

The Statewide Urban/Rural Women's Alcohol and Other Drug Abuse (AODA) Treatment Project provided grants for eight community and evidence-based women and family-centered treatment programs. The project serves adult women in need of AODA treatment who are also involved in at least

one other formal service system. Priority of treatment services is given to pregnant women. Annually, 435 women and 223 children are served.

Three criminal justice diversion projects called the Treatment Alternative Program are funded by the Wisconsin DHS. The program is based upon the successful Accountability for Safer Communities model. The program operates in three urban counties and serves several hundred offenders each year.

The Wisconsin DHS awarded grants to four county treatment agencies in northwest Wisconsin, Barron, Burnett, Polk and St. Croix, where local officials have identified significant need for methamphetamine treatment using the Matrix Model. The agencies implemented the evidence-based Matrix Model and in concert with criminal justice agencies, have reduced the methamphetamine problem in the area.

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

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

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

The Alliance for Recovery Advocates **(**AFRA) is a statewide, consumer-driven, grassroots advocacy and support organization. AFRA includes people in the recovery community and allies of people in long term recovery. It is expected that a broad range of services will be made available to build and mobilize strong grassroots recovery organizations across the state. Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA) was the successful vendor of the AFRA Grant and will ensure the following:

- Create a statewide advocacy and advisory board called the Alliance for Recovery Advocates that would bring together men and women group members of diverse backgrounds, family members, supporters, and allies. The AFRA Advisory Board should be broadly representative of the recovery communities across Wisconsin.
- Create a self-sustaining, statewide consumer driven organization.
- Establish and maintain a strong affiliation with the National Faces & Voices of Recovery organization.
- Carry a strong message of hope to all affected by addiction that recovery is real.

- Ensure that AFRA has a presence and coordinates recovery activities in both urban and rural areas of the state.
- Organize and coordinate support and resources for the September Recovery Month activities occurring throughout the state.

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

Substance Abuse Prevention Services

Community Aids
Funding provided from the SAPT block grant is distributed to county governmental entities through community aids as a categorical allocation. As in past years, counties are required to spend these funds on eligible substance abuse services, including 20% on primary prevention services. Recipients of these funds are also required to identify services within Center for Substance Abuse Prevention's (CSAP) six-prevention strategy areas. Funds support prevention services and activities to reduce youth substance abuse among residents in each Wisconsin county and tribe. Services are delivered either directly through one of the states' county administered human service agencies or via a sub-contact with a local provider. Programs established with these funds must comply with DHS 75, Community Substance Abuse Service Standards. Counties are required to comply with applicable SAPT Block Grant guidelines. Funds will be distributed via State/County contracts on a calendar year contract period.

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

Wisconsin Clearinghouse for Prevention Resources (WCH)
WCH continued to support the five Alliance for Wisconsin Youth Regional Prevention Centers by coordinating statewide training and technical assistance services. The Wisconsin Clearinghouse also was the lead agency in developing and coordinating the Wisconsin Annual Statewide Prevention Conference in June 2012. The Wisconsin Clearinghouse also serves as the lead agency in coordinating the Parents Who Host Lose the Most campaign, the Prevention Speaks project, and the Transform Wisconsin Fund.

HIV Prevention Program
SAPT block grant funds continued to support HIV prevention education services targeted towards substance abusers and their sexual and/or needle sharing partners living in the Milwaukee, Wisconsin area. Service providers were prohibited from using funds for the purchase of inpatient hospital services, syringes, needles or condoms. The Department contracted for these services through the Wisconsin Division of Public Health's HIV Prevention Program.

Brighter Futures Initiative (BFI)
This initiative merged ten categorically funded youth prevention programs and combined funds, staff, and resources towards a new youth development effort. Funding used to support this initiative is derived from several state and federal sources (i.e., Substance Abuse Block Grant, Wisconsin General Purpose Revenue, and Temporary Assistance for Needy Families). Local county BFI grantees are required to pool

resources, leverage additional county administered dollars, and meet community driven outcomes. The overall goal of this program assists youth and families to be safe, healthy, self-sufficient members of their community.

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

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

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

Mental Health and Substance Abuse Services for Adults

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

Comprehensive Community Services and Community Support Programs
CCS and CSP attempt to eliminate "silos" of services. CCS utilizes an advisory committee which includes external providers and other interested parties, in addition to consumers and families. As committee members, the providers and interested parties are able to provide feedback to the CCS program regarding policies, practices and procedures that are recovery-oriented and person-centered. Services must be psychosocial rehabilitative in nature, meaning that they must result in greater independence or minimizing the effects of the illness. The services should reflect positive results on quality indicators,

participation on recovery teams, compliance with supervision and training to keep the staff skills current, and culturally competent services.

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

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

Community Recovery Services (CRS)

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

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

1) Community Living Supportive Services (CLSS) covering services necessary to allow individuals to live with maximum independence in community integrated housing including skill training, cuing and/or supervision as identified by the person-centered assessment.

2) Supported Employment Services includes services necessary to assist individuals to obtain and maintain competitive employment using Individual Placement and Support (IPS) model recognized by SAMHSA as an evidence-based practice.

3) Peer Support Services utilizing individuals trained and certified as Peer Specialists to serve as advocates, provide information and peer support for consumers in outpatient and other community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process.

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

Services for Youth

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

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

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

Children's Long-Term Support Waivers
Children's Long-Term Support (CLTS) waivers, managed by the Division of Long-Term Care, address the needs of children age 17 and under who meet different federal target groups, including physical disabilities, SED and developmental disabilities. For children with SED, the eligibility age extends out to age 21. Aside from age and disability, the CLTS wavier requires that the child live at home but require services at the level of care typical to an intermediate care facility for the mentally retarded (ICF-MR), nursing home, or psychiatric hospital. Moreover, the cost of care under the waiver program must not exceed that which it would cost to provide services in such an institution. Each of the approved waivers provides community supports and services to children with significant disabilities and long-term support needs. The waivers offer services such as service coordination, supportive home care, respite care, specialized medical and therapeutic supplies, and other supports for children. The waivers also include intensive in-home autism treatment services. The community supports available through the waiver are cost-effective and assure that children are at home with their families.

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

Services for Older Adults

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

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

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Services for Special Populations

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

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

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

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

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

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

peer specialists, and a hybrid of other models such as PACT, ACT, and Forensic Intensive Case Management (FICM).

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

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

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

Services under this program have three primary goals:
1. Prevent or reduce the complications associated with IV Drug Use.

2. Improve access to treatment for persons who use IV Drugs.

3. Provide outreach, prevention and treatment for IV drug abusers.

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

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

Access to services, prompt and adequate care and providers who are culturally competent are essential component for persons needing assistance. Programs must consider the gender, culture and environmental background of the person being served in order to render the most appropriate and effective services.

Outreach services extend beyond usual agency activities to engage individuals who have, or are at risk of developing, a substance use or related health problem. Outreach focuses on reaching those who are “hard to reach or hidden” and not in contact with other services. Outreach activities may also be designed to reach people already in contact with services but who need accessible substance abuse treatment services.

The development of outreach services are based on a careful assessment of the characteristics, life circumstances, and needs of the specific group who will receive the services. In some cultures, men and women live more segregated lives and this is taken into account in planning Wisconsin’s outreach services. In some cases, such as homeless women, safety may be the primary concern.

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

Women with Substance Abuse Disorders
In 2012, the Division of Mental Health and Substance Abuse Services made $2,429,631.00 per year available to fund programs of no more than $500,000 for a single agency and $750,000 for a consortium or regional partnership. This grant is designed to address the multiple needs of women and their families to access family-centered services for their substance use disorders. These services are gender, culturally and linguistically relevant and focus on the empowerment of women to develop the necessary skills for long-term sobriety, improvement of parenting skills, relationship building, and to encourage education and job skills that promote family self-sufficiency. These services also include, where appropriate, mental health, trauma responsive approaches, therapeutic childcare, transportation and community, natural and recovery supports and/or other services that are necessary to provide wraparound care to women and their families.

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

Family-centered treatment offers a solution to an intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve family functioning, child health and safety.

This grant provides an opportunity to target women, as well as achieve and identify improved outcomes for evaluation. For women with children this grant provides therapeutic childcare services as necessary for treatment.

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

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

Individuals with HIV/AIDS
In 2011, 285 new cases of HIV infection were reported in Wisconsin. Over the past decade rates of HIV infection have remained stable, however cases among injection drug users (IDUs) have declined in Wisconsin (-25%) from 2002 to 2011, accounting for 8% of cases in 2011. The majority of IDU cases

were White male (64%). Men who have sex with men (MSM) accounted for 72% of new cases reported in 2011, including 3% of cases among MSM who were also injection drug users. Cases of HIV infection have increased among MSM by 29% from 2002 to 2011. A 218% increase in young Black MSM ages 15-29 has occurred in addition to a 64% increase among young White and a 21% increase among young Hispanic MSM (Wisconsin HIV/AIDS Strategy, 2012).

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

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

Rural Areas

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

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

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

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

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Inadequate workforce capacity can sometimes be due to a geographical mismatch between available workers and consumers in need.

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

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

Services to Individuals Who are Homeless

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

Over the past five years, there have been increasing numbers of homelessness reported through the Homeless Information Management System (HMIS), which in Wisconsin is known as Wisconsin Service Point (WISP). Over those five years, the number of reported homeless has risen over 20 percent (from 27,528 in the year 2008 to 34,583 in through November 2012). Over the same period the number of chronic homeless declined from just over 9 percent to a low of just over 6 percent in 2010. However, as of November 2012 those who are chronically homeless comprised 11 percent of the homeless population in Wisconsin (4,057 to 5,205).

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

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

Within DOA, one critically important Substance Abuse and Mental Health Services program is the Projects to Assist in the Transition from Homelessness (PATH). The central objective of PATH is outreach to locate and engage people experiencing homelessness who have a mental illness or co-occurring disorder and to facilitate enrollment in PATH services.

Additionally, the United States Department of Housing and Urban Development (HUD) supported housing initiatives exist in both urban and rural communities across the state, funding transitional and permanent housing programs. HUD funds several levels of supportive housing including Safe Havens, Transitional Housing, and Shelter-Plus-Care. Although no new Safe Haven projects are being funded through HUD, existing programs provide a soft entry refuge for people who are unable or unwilling to immediately engage in supportive services.

Another important initiative in the state is Wisconsin's Real Choice Systems Change Grant: Building Sustainable Partnerships for Housing. The Frank Melville Supportive Housing Act of 2011 revitalized and reformed the HUD Section 811 Supportive Housing for Persons with Disabilities Program. DHS and the Wisconsin Housing and Economic Development Authority (WHEDA) are currently partnering to plan implementation of the new HUD Section 811 program in Wisconsin. Led by the Bureau of Long Term Support in DHS and Housing Specialists within the "Money Follows the Person" program, it emphasizes community integration and relocation for persons with disabilities and frail elders who transition out of institutions. Members from community organizations, developers, healthcare providers and advocates are all part of this planning effort through the "housing workgroup." Primarily efforts of the project are to: 1) create a new and sustainable relationship between DHS and WHEDA, 2) educate and provide technical assistance to developers about the benefits of the reformed Section 811 program and the clientele these projects can serve; 3) establish a new housing counseling curriculum to be used by provider agencies serving members in the community and to provide technical assistance during the implementation stage as well as on a case-by-case basis; 4) create a new independent housing referral process utilizing the current infrastructure of the long-term care system.

SSI/SSDI Outreach, Access and Recovery (SOAR) is another vital initiative supported by the DHS Bureau of Prevention Treatment and Recovery that has helped many homeless and disenfranchised individuals obtain urgently needed disability benefits and related insurance, enabling the person to have a life off of the street. Disability benefits help pay the rent; whereas medical insurance enables access to medical and behavioral health treatment. Considering the loss of the Homeless Specialist requirement for the Social Security offices, SOAR has an even more important role.

Deaf, Deaf-Blind, Hard-of-Hearing and Behavioral Health
While the numbers of persons with hearing loss is not a large proportion of the population, many challenges exist for those who do have hearing loss in a variety of ways related to cultural competency

and linguistic appropriateness. Communities of those with hearing loss tend to be quite small and diverse.

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

The Strategic Plan was founded on seven critical facts:

1. Many people in the deaf, deafblind and hard of hearing community do not receive mental health and/ or substance abuse services that meet his or her needs. The term “services” includes prevention, active treatment, supported transition and after-care.
2. People who are deaf, deafblind and hard of hearing and their families often do not have an understanding of mental health, mental illness and AODA including co-occurring disorders/problems and the related impact with physical health.
3. Society lacks a meaningful understanding and sensitivity about the experiences and needs of people who are deaf, deafblind or hard of hearing.
4. People working in mental health/substance abuse and relat6ed systems often do not meaningfully understand the experiences and culture of deafness.
5. There is a lack of thorough, accurate epidemiological data at the state and federal levels regarding mental health and AODA needs and treatments by persons who are deaf, deafblind or hard of hearing.
6. Sustainable resources and funding are needed to create the capacity to implement this plan and achieve the vision.
7. It will be neither quick nor easy to create change so that people of all ages who are deaf, deafblind or hard of hearing received mental health and substance abuse AODA services that meet the unique needs of each individual.

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

1. Increasing understanding among individuals who are deaf, deaf-blind or hard of hearing and their families/social supports about mental health and Alcohol and Other Drug Abuse (AODA) and recovery.
2. Increasing understanding within the mental health and AODA systems about how to provide effective services for individuals who are deaf, deaf-blind, or hard of hearing.
3. Expanding system capability and sustainable resources and funding for improved access to communication, technology, and peer/family supports.

4. Developing long-term collaborative partnerships between people who are deaf, deaf-blind and hard of hearing, their families, and representatives of mental health and AODA systems and relevant others.
5. Collecting meaningful data on prevalence, gaps/needs of services to address the mental health, AODA, and health care needs of individuals who are deaf, deaf-blind, and hard of hearing and their families.

These goals to improve mental health and substance abuse services to the population of those with hearing loss were then reviewed with a group of about 80 invited stakeholders at a highly successful day-long summit in March 2012. From the summit, plans were developed and prioritized for implementation.

Out of the summit were convened several workgroups to advance the goals of the Strategic Plan. Each workgroup is implementing a work plan. Workgroups engage in cross-workgroup collaboration and call in outside expertise for consultation. The initial workgroups are as follows:

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

Strengths of the Wisconsin Mental Health and Substance Abuse Services System

Wisconsin over the years has served as a leader in many initiatives, modeling developments in the behavioral health infrastructure for other states. Pioneering efforts in community mental health in psychosocial rehabilitation were researched in Wisconsin through PACT (or Programs for Assertive Community Treatment). Around the same time, in the 1970s the National Alliance on Mental Illness (NAMI) was founded in Wisconsin. DMHSAS is working with NAMI-Wisconsin, WAAODA, MRPC, WADTPA, AFRA, Wisconsin Family Ties (WFT), Mental Health Association of Wisconsin (MHA), Disability Rights Wisconsin (DRW), Grassroots Empowerment Program, Inc. (GEP), Wisconsin United

for Mental Health (WUMH) to continue development of Wisconsin's behavioral health infrastructure for adults and children. These groups are also working to counter stigma and discrimination in Wisconsin while conveying accurate and unbiased information about mental illnesses, severe emotional disturbance, and substance use disorders in the interest of promoting recovery and the adoption of evidence-based practices.

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

Certified Peer Specialists
Under the leadership of the Bureau of Prevention Treatment and Recovery (BPTR) and Access to Independence, Inc. an independent living center has developed a certification process for peer specialist services. Proof of required training and a state sponsored exam are the central components of the process. The independent living centers in the state serve as exam proctors; the University of Wisconsin-Milwaukee manages the tests and scores the results.

DMHSAS also partners with the University of Wisconsin (UW)-Madison School, of Medicine and Public Health to provide Recovery technical assistance. DHMSAS continues to work with the Recovery Implementation Task Force (made up of a majority of consumers) to provide advice on a range of initiatives that promote recovery.

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

Supporting Purpose for Consumers
Wisconsin's strengths within the realm of SAMHSA's vision of purpose in the community is the web of employment resources from Wisconsin's network of Job Centers in many communities, the provision of vocational rehabilitation services through the Department of Workforce Development (DWD), Division of Vocational Rehabilitation (DVR) and a variety of other efforts such as supported employment initiatives through a continuum of psychosocial rehabilitation programs. Employment agencies use

Ticket to Work (TTW) vouchers to assist individuals in navigating a difficult employment environment. Many technical college and university campuses have special needs counselors or programs which can help persons with disabilities successfully complete training programs. A network of twelve Cooperative Educational Service Agencies (CESA) across the state supply supportive and educational services, employment assistance, job coaching, and a host of other services, each to their own respective region. Similarly, eight Independent Living Centers (ILCs) across the state are consumer-directed, non-profit organizations that provide four core services: (1) peer support; (2) information and referral; (3) independent living skills training; and (4) person and systems advocacy.

Use of Evidence Based Practice

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

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

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

Conditional Release Program

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

The Conditional Release Program has funded, coordinated and administered quality forensic mental health services to 431 clients during FY12, with an average daily population of 284 clients. The overall mission of the program is community safety by assisting clients to achieve their highest level of mental

health and independent functioning has been met this year. The outcome indicators for mental health stability and highest levels of independent functioning include independent living situations and employment. Clients have been very successful, as evidence by the fact that 78% live in independent living situations and 39% are employed or going to school. The number of Conditional Release clients living independently of CBRF's has increased 2% over last year.

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

The Conditional Release program will continue supporting the development of skills such as Motivational Interviewing, Person Centered Planning, developing Trauma informed case managers and resources and identify the Stage of Change and engage clients in a process to go forward in the stages of change to recovery. Along with these measures, many performance goals/expectation performance standards have been increased and performance expectations will again be measured for FY13.

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

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

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

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

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

Description of the Wisconsin Needs Assessment Process

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

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

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

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

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

Collaboration With Other Agencies to Identify Overall Unmet Behavioral Health Need

The focus of the first two sections of the needs assessment report was to identify the prevalence of needs, the access to services (number of clients served), and the difference between the two which represents the

unmet need in Wisconsin. While the DMHSAS collects data for the public county mental health and substance abuse service systems, it does not typically have access to data from other state agencies that provide or pay for behavioral health services. However, for the needs assessment, the DMHSAS worked with State mental health institutes, the state long-term care agency, the state corrections agency, and the state Medicaid agency in a coordinated effort to calculate an unduplicated count of behavioral health consumers served in a year. The effort also included data from commercial insurers who fund behavioral health services in the private sector. The count of clients served across these different sectors is designed to provide an assessment of unmet need that is more comprehensive than previous efforts.

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

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

Switching now to substance abuse treatment access issues, how many persons who need treatment get treatment? The 2010 National Survey of Substance Abuse Treatment Services – Wisconsin sample, found that there were 306 persons in treatment on any given day per 100,000 population or a total of 17,385 persons. The national average across states is 381 persons in treatment per 100,000 population indicating that Wisconsin's rate of treatment is 20% below the national average in this study.

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

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

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

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

Quantitative Data Sources for the Needs Assessment

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

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

Consumer and Advocate Input

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

- Healthcare
- Prevent mental health hospitalizations
- More consumer-run support groups or centers
- More Peer Specialists
- Prevent or provide mental health services for persons who come in contact with the criminal justice system
- Address stigma and discrimination
- Protect or increase public funding for mental health services
- Affordable public or private health insurance

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Tribal Nations Input

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

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

Unmet Needs and Gaps

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

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

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

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Wisconsin Ranked List of Needs

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

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

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TABLE 1a: FFY 2014-2015 Substance Abuse Treatment and Prevention Block Grant Priorities

Priority Type	Targeted/required populations	Goal of the priority area	Strategies to attain the goal	Annual Performance Indicators
Substance Abuse Treatment **REQUIRED FEDERAL**	Individuals with tuberculosis.	100% of all certified AODA treatment agencies in Wisconsin will be compliant with Wisconsin TB information and referral policies.	• In cooperation with the Wisconsin Division of Quality Assurance, identify agencies in non-compliance with TB information and referral policies and provide follow-up technical assistance to ensure compliance.	The rate of treatment agencies in compliance with TB information and referral policies vs. total agencies certified or re-certified will be 100%.
Substance Abuse Prevention **REQUIRED FEDERAL**	Persons who are intravenous drug users (IDU).	Increase prevention, street outreach and access to recovery-oriented treatment for injection drug users (IDU).	• Realign existing funding to have increased emphasis on prevention and early intervention; provide education and training to street outreach teams; • Strengthen collaborations among agencies serving IDUs.	Increase treatment admissions among injection drug users by 2% over baseline of approximately 1,200 annual admissions.
Substance Abuse Treatment Substance Abuse Prevention **REQUIRED FEDERAL**	American Indians/Alaska Natives Underserved racial and ethnic minorities.	Improve access to recovery-oriented services for special populations such as Hispanic/Latinos, African Americans, Asians, American Indian, Military Families, Deaf and Hard of Hearing, and LGBTQ populations.	• Regularly monitor treatment services provided to special populations to assure the proportion of racial, ethnic and cultural individuals being served are comparable to their occurrence in the general population. • Provide technical assistance to provider community to improve access to services for special needs populations.	The proportion of racial, ethnic individual persons served will be comparable to their occurrence in the general population including adjustments for their incidence of substance use disorders.
Substance Abuse Prevention **REQUIRED FEDERAL**	Youth substance use.	Reduce youth access to tobacco products and maintain at retail outlets non-compliance rates of less than 10%.	• Continuation of implementation of Wisconsin Wins compliance checks, media outreach and public outreach through the Division of Public Health's Tobacco Prevention and Control Program.	Proportion of successful attempts to purchase tobacco products by young people will be below 10%. The CY 2010 rate was 4.7%.

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Priority Type	Targeted/required populations	Goal of the priority area	Strategies to attain the goal	Annual Performance Indicators
Substance Abuse Treatment Substance Abuse Prevention **REQUIRED FEDERAL**	Women who are pregnant and have a substance use disorder. Parents with substance use disorder.	Increase the number of women specific recovery-oriented evidence based services or programs within 5 counties or tribes with a focus on pregnant women or women with dependent children.	• Develop and provide statewide training and consultation on the expansion of Evidence Based Practices.	Record and documentation of the number of counties or tribes implementing women specific evidence based practices.
Substance Abuse Services	Individuals with mental and/or substance use disorders involved in the criminal justice system.	Increase the use of effective and recovery-oriented evidence-based services for substance use disorders for persons coming in contact with the criminal justice system.	• Provide statewide training and consultation of evidence based programs. • Assist counties in assessing system strengths and needs. • Assist counties in identifying outcome measures. • Conduct collaborative meetings no fewer than four times a year. •	Through training and consultation, record and document the number of new evidence based practices that have been implemented.
Substance Abuse Prevention Substance Abuse Treatment	Environmental/policy prevention activities. Individuals with risky use of substances or with substance use disorders.	Reduce the number of alcohol-related motor vehicle fatalities by 2% for individuals between the ages of 16 – 34).	• Partner with DOT to enhance law enforcement capacity to address alcohol laws. • Partner with the University of Wisconsin Law School Alcohol Policy Project to provide training on best practices for coalitions working to reduce drunk driving. • Working with community Alliance for Wisconsin Youth Coalitions, promote the following preventative interventions: A) Implement saturation patrols during targeted time periods such as the post-closing hours. B) Promote the prosecution and adjudication with sanctions of alcohol law violations within the municipal court system. C) Establish evidence based "best practices" for local retailers including; no consumption based drink specials, all staff trained, refusal to serve all patrons under age 21, annual review of ID check procedure and identifying intoxicated patrons with law enforcement. Off premises "Class A" retailers agree to restriction on "tastings" and restrictions on POS advertising. • Provide funding to support evidence based practices for	Number of alcohol-related motor vehicle fatalities as measured by the National Highway Traffic Safety Administration's Fatality Analysis Reporting System (FARS) and The Wisconsin Department of Transportation's Wisconsin's Traffic Crash Facts is reduced by 2%.

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			OWI clients seeking SA treatment • Increase number of OWI courts or provide development grants for existing or new courts to implement evidence based practices.	
Substance Abuse Prevention	Individuals in need of primary substance abuse prevention.	Reduce the non-medical/unauthorized use of prescription opiates.	• Promote best practices for reducing prescription drug availability including practices for prescribers and dispensers as well as for proper medication disposal. • Raise awareness among parents, youth, patients, and health care providers. • Collaborate with DSPS on the implementation of Wisconsin's PDMP.	2% reduction in consumption rates as measured by the CDC's Youth Risk Behavior Survey and the National Survey on Drug Use and Health (WI Sample).

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Table 1b: FFY 2014-2015 Community Mental Health Services Block Grant Priorities

Priority Type	Targeted/required populations	Goal of the priority area	Strategies to attain the goal	Annual Performance Indicators
Mental Health Services Substance Abuse Services	Children with Serious Emotional Disturbance.	Increase the access and quality of wraparound services for children and youth through the expansion of the number of counties and/or tribes with Coordinated Service Teams (CST) programs.	• Provide additional state budget resources to increase the number of counties and / or tribes covered by CST Initiatives statewide, • Provide technical assistance to those areas of the state/tribes without CST programs. • Review data on child and family outcomes of CST programs and identify quality improvement objectives. • Explore ways to expand child psychiatry consultation for children served by CST programs.	Count of Counties and / or tribes covered by CST programs.
Mental Health Services Substance Abuse Services	Adults with Serious Mental Illness. Children with Serious Emotional Disturbance.	Improve access and quality of recovery-oriented mental health and substance abuse services that promote evidence-based practices through increasing the number of people served in psychosocial rehabilitation programs, such as Comprehensive Community Services (CCS), Community Support Programs (CSP), Community Recovery S, peer support, and supported employment.	• Expand budget authority for Comprehensive Community Services (CCS) thru Governor's budget initiative for the state to assume nonfederal share of MA. • Work with counties and tribes to develop CCS programs in all areas of the state. • Develop and monitor performance indicators for CCS programs; implement quality improvement projects as needed in areas needing performance improvement. • Promote in CCS/CSP service arrays Peer Specialists, Supported Employment, and Family Psycho-education in order to meet individual needs using these EBPs. • Research and develop Peer Run Respite and Warmlines • Support Peer Run Recovery Centers.	Number of persons served through CCS and CSP programs.
Mental Health Services	Individuals with mental disorders involved in the criminal justice system.	Promote effective and recovery-oriented and evidence-based practices (EBPs) for people with mental illness who are involved in criminal justice system thru consultation with county systems.	• Consult with an existing model programs/national experts to identify key EBPs for local court/law enforcement can make to improve their systems. • Provide EBP training for county criminal justice and mental health systems. • Expand Mendota Forensic units to more quickly provide needed mental health treatment for those individuals in jail who need treatment to competency.	Number of counties that have been provided consultation.

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SECTION 3:
Use of Block Grant Dollars for Block Grant Activities

Section contents:

1. **Plan Table 2a – State Agency Planned Expenditures (SA)**
2. **Plan Table 2b – State Agency Planned Expenditures (MH)**
3. **Plan Table 5a – SABG Primary Prevention Planned Expenditures**
4. **Plan Table 5b – SABG Primary Prevention Planned Expenditures**
5. **Plan Table 5c – SABG Planned Primary Prevention Targeted Priorities**
6. **Plan Table 6a – SABG Resource Development Activities Planned Expenditures**
7. **Plan Table 6b – MHBG Non-Direct Service Activities Planned Expenditures**

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III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]
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Planning Period - From SFY 2014 to SFY 2015

Activity (See instructions for using Row 1.)	A. Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$42,106,400		$104,300	$4,182,900	$3,885,600	$	$
a. Pregnant Women and Women with Dependent Children	$ 6,461,600		$	$	$ 701,900	$	$
b. All Other	$ 35,644,800		$ 104,300	$ 4,182,900	$ 3,183,700	$	$
2. Primary Prevention**	$ 13,467,600		$	$ 2,377,100	$ 3,313,100	$	$
3. Tuberculosis Services	$		$	$	$ 596,200	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care			$	$	$	$	$
7. Ambulatory/Community Non -24 Hour Care			$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 187,400		$	$	$ 358,800	$	$
9. Subtotal (Row 1, 2, 3, 4 and 8)	$55,761,400	$	$104,300	$6,560,000	$8,153,700	$	$
10. Subtotal (Row 5, 6, 7 and 8)	$187,400	$	$	$	$358,800	$	$
11. Total	**$55,761,400**	**$**	**$104,300**	**$6,560,000**	**$8,153,700**	**$**	**$**

* Prevention other than primary prevention

** States may only use MH Block Grant funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with serious emotional disturbance.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]
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Planning Period - From SFY 2014 to SFY 2015

Activity (See instructions for using Row 1.)	A. Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment			$	$	$	$	$
a. Pregnant Women and Women with Dependent Children			$	$	$	$	$
b. All Other			$	$	$	$	$
2. Primary Prevention**		$ 358,600	$	$	$	$	$
3. Tuberculosis Services			$	$	$	$	$
4. HIV Early Intervention Services			$	$	$	$	$
5. State Hospital		$	$	$	$ 234,091,600	$	$ 344,800
6. Other 24 Hour Care			$	$	$	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 13,557,700	$ 744,300	$ 600,000	$ 29,430,800	$	$
8. Administration (Excluding Program and Provider Level)		$ 74,200	$	$	$	$	$
9. Subtotal (Row 1, 2, 3, 4 and 8)	$	$432,800	$	$	$	$	$
10. Subtotal (Row 5, 6, 7 and 8)	$	$13,631,900	$744,300	$600,000	$263,522,400	$	$344,800
11. Total	**$**	**$13,990,500**	**$744,300**	**$600,000**	**$263,522,400**	**$**	**$344,800**

* Prevention other than primary prevention

** States may only use MH Block Grant funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with serious emotional disturbance.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$ 518,996	$ 518,996
	Selective	$ 46,577	$ 46,577
	Indicated	$ 99,807	$ 99,807
	Unspecified	$	$
	Total	**$665,380**	**$665,380**
Education	Universal	$ 1,657,462	$ 1,657,462
	Selective	$ 1,269,545	$ 1,269,545
	Indicated	$ 599,507	$ 599,507
	Unspecified	$	$
	Total	**$3,526,514**	**$3,526,514**
Alternatives	Universal	$ 308,736	$ 308,736
	Selective	$ 165,014	$ 165,014
	Indicated	$ 58,554	$ 58,554
	Unspecified	$	$
	Total	**$532,304**	**$532,304**
Problem Identification and Referral	Universal	$ 74,523	$ 74,523
	Selective	$ 82,507	$ 82,507
	Indicated	$ 109,122	$ 109,122
	Unspecified	$	$

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 2,221,581	$ 2,221,581
Universal Indirect	$ 965,213	$ 965,213
Selective	$ 2,001,585	$ 2,001,585
Indicated	$ 1,465,421	$ 1,465,421
Column Total	**$6,653,800**	**$6,653,800**
Total SABG Award	**$**	**$**
Planned Primary Prevention Percentage		

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities
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Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☐
Prescription Drugs	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☐
American Indians/Alaska Natives	☑
African American	☑
Hispanic	☑
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☑
Rural	☑
Underserved Racial and Ethnic Minorities	☑

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 25,000	$	$	$25,000	$ 25,000	$	$	$25,000
2. Quality Assurance	$	$	$	$	$	$	$	$
3. Training (Post-Employment)	$ 7,000	$	$	$7,000	$ 7,000	$	$	$7,000
4. Education (Pre-Employment)	$	$	$	$	$	$	$	$
5. Program Development	$ 25,900	$	$	$25,900	$ 25,900	$	$	$25,900
6. Research and Evaluation	$	$	$	$	$	$	$	$
7. Information Systems	$ 14,038	$	$	$14,038	$ 14,038	$	$	$14,038
8. Total	$71,938	$	$	$71,938	$71,938	$	$	$71,938

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

Service	Block Grant
MHA Technical Assistance Activities	$ 412,700
MHA Planning Council Activities	$ 9,200
MHA Administration	$ 37,100
MHA Data Collection/Reporting	$ 39,700
MHA Activities Other Than Those Above	$ 121,000
Total Non-Direct Services	$619700
Comments on Data	

Footnotes:

SECTION 4:
Narrative Plan

Section Contents:

C Coverage for M/SUD Services
D Affordable Insurance Exchange
E Program Integrity
F Use of Evidence in Purchasing Decisions
G Quality
H Trauma
I Justice
J Parity Education
K Primary and Behavioral Health Care Integration Activities
L Health Disparities
M Recovery
N Prevention
O Children
P Consultation with Tribes
Q Data and Information Technology
R Quality Improvement Plan
S Suicide Prevention
T Use of Technology
U Technical Assistance Needs
V Support of State Partners
W State Behavioral Health Advisory Council
Behavioral Health Council Composition by Member Type
X Comment on the State BG Plan

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C. Coverage M/SUD Services

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

Please answer the following questions:

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

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

Wisconsin's Governor has decided that Wisconsin will not elect to develop a Health Care Exchange. It is unclear whose responsibility it would be to monitor QHPs and access to services.

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

mental health and substance abuse services for the privately insured population, including the Qualified Health Plans if they report data into the WHIO.

In response to question four, in Wisconsin, the Office of the Commissioner of Insurance is responsible for any complaints or violations of insurance laws. To date, the SMHA/SSA has not been involved.

It is still too early to know about the impact of the Health Exchange mental health and substance abuse Qualified Health Plan coverage and exclusions in Wisconsin. A major portion of the Block Grants go to county agencies. The state contracts with county agencies that are already responsible under state law for those individuals who do not have access to mental health and substance abuse services thru health insurance (under insured) or for those without any health insurance coverage. Since this will be the same target population post ACA, the impact remains unclear. Wisconsin counties already contribute a considerable amount of local county tax levy for mental health and substance use services for these individuals and many counties report a waiting list for services.

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

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

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D. Affordable Insurance Exchange

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

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

Please answer the following questions:

- 1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
- 2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
- 3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
- 4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
- 5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
- 6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
- 7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
- 8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

In response to question one, the BPTR has included information on treated prevalence in its recent needs assessment and will anticipate using this method in the future to monitor trends in access to behavioral health services.

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

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

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

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

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

In a national study, 43% of adults with mental health or substance use conditions have incomes less than 150% of the federal poverty income level indicating a high need for public support for services. That is, if 100 people from the general population sought treatment for a mental health or substance use condition, what proportion of them would be the responsibility of the publicly-financed system? The National Survey on Drug Use and Health derives national estimates to answer this question from survey respondents who had sought treatment. Wisconsin's 2008 low income rate (having less than 185% of the federal poverty income level) is fairly close to the national average (WI 23.4% vs. U.S. 27.7%) so these

national estimates are applied to Wisconsin with some caution. The results are presented in the following table:

Consumer-reported Source of Payment for Mental Health and Substance Abuse Treatment

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

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

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

2011
Mental Health: 73,636 x.36 = 26,509 individuals served under the MHBG who are uninsured
Substance Abuse: 48,100 x .50 = 24,050 individuals served under the SABG who are uninsured

Assumptions
The federal health insurance exchanges and health insurance requirement are set to take effect in 2014 and it is estimated that the number of persons insured will rise in Wisconsin to that of Massachusetts at about 98%. Wisconsin's current population is 5,686,986 persons. Wisconsin's current rate of health insurance is estimated at 89%. An additional 4% are currently eligible for Medicaid, but have not enrolled. Therefore, Wisconsin is anticipating an approximately 10% increase in persons statewide who will be insured in 2014 (the increase from 89% to 98%) leaving an estimated 113,740 uninsured. Currently, the number of persons served under the block grants is declining slightly from year-to-year.

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

2013
Mental Health: 2011 baseline 26,509 – 1% (declining admissions) = 26,244 uninsured
Substance Abuse: 2011 baseline 24,050 – 2% (declining admissions) = 23,569 uninsured

2014
Mental Health: 2013 baseline 26,244 – 1% (declining admissions) = 25,982 – 10% (increase in uninsureds) = 23,384 uninsured
Substance Abuse: 2013 baseline 23,569 – 2% (declining admissions) = 23,098 – 10% (increase in uninsureds) = 20,788 uninsured

2015
Mental Health: 2014 baseline 23,384 – 1% (declining admissions) = 23,150 uninsured
Substance Abuse: 2014 baseline 20,788 – 2% (declining admissions) = 20,372 uninsured

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

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E. Program Integrity

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

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

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

- 1. Does the state have a program integrity plan regarding the SABG and MHBG?
- 2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
- 3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
    - a. Budget review;
    - b. Claims/payment adjudication;
    - c. Expenditure report analysis;
    - d. Compliance reviews;

- e. Encounter/utilization/performance analysis; and
- f. Audits.

- 4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
- 5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
- 6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

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

Since Wisconsin will not implement its own health exchange, the state may not have progressed as far as other states in planning for Affordable Care Act implementation. However, starting in CY 2013 Wisconsin has begun a three-year pilot project with two consortiums of county governments to develop regional collaborative development of shared mental health and substance abuse services. These contracts are funded with MHBG & SABG. A key element of these contracts will be development of a set of core benefits for mental health and substance abuse services and other policy initiatives to ensure our Block Grant funding will be used to effectively and efficiently implement the Affordable Care Act.

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

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

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

approved by the same parties.

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

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

On a monthly basis the Division's community program Budget and Policy Analyst produces an excel spreadsheet summary of the financial status of all block grant-funded contracts that is distributed BPTR supervisors and the BPTR Director. The report notes if individual block grant contracts have failed to expend funding in a timely manner. This report is reviewed in monthly meetings in which supervisors designate contract administrators to investigate and contact contract agencies that have failed to expend funds in a timely manner.

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

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

Encounter, utilization, and performance analysis reports are created to analyze block grant funded agency process using the HSRS and SAPSIS data systems by Bureau staff. These reports are reviewed by Division data specialists, contract administrators, supervisors, the Bureau Director. The results of these reports are also incorporated into a Division wide annual performance report.

Agencies receiving block grant contract awards of $25,000 or more are required to submit single audit reports to Department staff that include a review of adherence to federal block grant requirements. These

reports are reviewed by personnel in the DHS Office of Inspector General (OIG). Any findings of significance are passed along to Division's Bureau Director and community program Budget and Policy Analyst. These findings are discussed with the contract administrator and his or supervisor who lead an investigation of the findings and develop a corrective action or response plan. If the agency succeeds in adequately addressing the finding issues the Division's approves it and signs off on the audit with OIG.

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

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

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F. Use of Evidence in Purchasing Decisions

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

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

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
    a) What information did you use?
    b) What information was most useful?

3) How have you used information regarding evidence-based practices?
    a) Educating State Medicaid agencies and other purchasers regarding this information?
    b) Making decisions about what you buy with funds that are under your control?

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

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

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

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

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

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

evidence based practice into the system contains a contractual obligation that the contractee adhere to fidelity of the evidence based practice.

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

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G. Quality

Narrative Question:
Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

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

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
2) Please provide information on any additional measures identified outside of the core measures and state barometer.
3) What are your states' specific priority areas to address the issues identified by the data?
4) What are the milestones and plans for addressing each of your priority areas?

Wisconsin will address this question once the Behavioral Health Barometer is available.

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H. Trauma

Narrative Question:

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

Please answer the following questions:

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

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

specific policy directive. The adoption of TIC is largely the result of an engaged consumer base and willing provider partners.

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

TIC Objectives:

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

Outreach Across Systems
Essential to promotion of these statewide objectives is cross-systems' TIC exposure and engagement. To date, with consultation and leadership from the TIC Consultant, the Departments of Public Instruction (DPI), Corrections (DOC), and Children and Families (DCF) have incorporated TIC into staff training and have begun implementation of action steps. Several of these steps include the following: the DPI developed TIC tools to be distributed to Wisconsin schools which are located on their *Creating Trauma Sensitive Schools* website, a TIC focused child welfare (DCF) leadership committee which includes the First Lady of Wisconsin and Casey Family Programs, actively promotes TIC transformation and trauma-specific interventions across child-serving systems. Robert Anda, co-principal investigator for the *Adverse Childhood Experience* (*ACE*) Study, presented ACE material to cabinet leadership at a dinner held at the Executive Residence and hosted by Wisconsin's First Lady, and collaborative partners purchased the *2010 Adverse Childhood Experience* (*ACE*) module which was included in that year's Wisconsin *Behavioral Risk Factor Survey*. The resulting data was published by the Wisconsin Children's Trust fund in January, 2012.

Consumer Involvement
Assertive efforts to assure meaningful consumer involvement are a part of the TIC initiative in Wisconsin. TIC has become a central theme included in consumer conferences and peer specialist trainings. A group

of TIC trained peer leaders are regularly asked to present TIC concepts to a wide range of consumer and provider groups and are paid for their time and knowledge.

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

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

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I. Justice

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

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

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

Please answer the following questions:

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

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

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

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

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

Institutional Services to Correctional Populations

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

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

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

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

transition back to the community.

Community Forensic Services

Conditional Release Program
The Conditional Release Program serves persons who have been adjudicated not guilty by reason of mental disease or defect and have been afforded the opportunity to transition into the community under judicial authority. When mental health professionals can make appropriate arrangements for an individual to be released safely to the community, or who has been stabilized in the state institutes to be released under a Judge's authority to community supervision, the individual can regain some of the natural supports of community living and save the state costs of confinement. Through the Conditional Release Program, many are able to return to community living, securing supports and developing relationships with treatment providers before their commitment period expires. The Conditional Release Program has funded, coordinated, and administered quality forensic mental health services to 431 clients in FY 2012, with an average daily population of 284 clients. Community safety remains the programs first priority.

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

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

Outpatient Competency Evaluation Program
The Outpatient Competency Evaluation Program began on January 1, 2002 with the anticipation that 75% of competency examinations could be done on an out-of-institution basis. The data indicates that since the program's inception, over 90% of the defendants have been able to be successfully examined in the community. The program continues to significantly exceed its goal and thus there was much less of a

drain on the institutional resources and many more cases could be handled by the courts without the time delays associated with inpatient examinations. Moreover, fewer individuals had to undergo involuntary forensic inpatient commitments in order to resolve the competency questions and those that were adjudicated incompetent had access to treatment quicker. The fact that the courts and jails continue to give very favorable reviews reinforces the successfulness of the Outpatient Competency Evaluation Program.

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

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

Substance Abuse Treatment Alternatives

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

juvenile drug courts. Depending on the area of the state the juvenile justice staff may be involved with professional networks like the Milwaukee Co-Occurring Competency Cadre.

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

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

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

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

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

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

Treatment Alternatives and Diversion (TAD) Program
In 2005, Wisconsin Act 25 authorized grants to counties to establish and operate programs, including suspended and deferred prosecution programs and programs based on principles of restorative justice, that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs. As a result, collaboration among the Wisconsin Office of Justice Assistance (OJA), the Wisconsin DOC, and the Wisconsin DHS established the Treatment Alternatives and Diversion (TAD) grant program in 2006. The program began with the implementation of the program at seven sites with expansion to an additional site in 2012. All TAD sites provide participants with case management, substance abuse treatment, drug testing and monitoring, but vary in program model/approach, length, treatment intensity, and target population. Four of the TAD sites are adult drug treatment courts and four sites utilize diversion models.

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

to education, employment, housing, behavioral health needs, health care, trauma, family/relationships, parenting, social networks, cognitive skills and attitudes, and emotional functioning and problem solving.

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

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J. Parity Education

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

Please answer the following questions:

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

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

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

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

K. Primary and Behavioral Health Care Integration Activities

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

Please answer the following questions:

- 1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
- 2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
- 3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
- 4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
- 5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
- 6. Describe how your behavioral health providers are screening and referring for:
    - a. heart disease,
    - b. hypertension,
    - c. high cholesterol, and/or
    - d. diabetes.

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

DHS is also piloting several coordinated care initiatives under the 1937 SPA. The Foster Care Medical Home has been approved by CMS and is expected to be implemented by May 2013 as a pilot in six counties in southeast Wisconsin. It is a joint initiative with the Department of Children and Families, Division of Long Term Care, Birth to Three, and other entities. It will coordinate physical and other forms of care for approximately 2500 children in foster care in the region. DHS is also currently undertaking program design on a pilot for an integrated care model for consumers in fee-for-service

Medicaid Department who have mental illness and one or more chronic physical conditions. This pilot is expected to be implemented in late 2013 or early 2014.

An integrated care model is currently under development in Wisconsin. This model considers FQHCs community health centers and other primary care practices, and publicly funded behavioral health providers to be potential partners in the delivery of mental health and substance abuse services.

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

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

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

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

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

- Metabolic Syndrome

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

Additionally the survey asks how many consumers use tobacco, abuse alcohol or abuse other drugs.

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L. Health Disparities

Narrative Question:

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

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

In the space below please answer the following questions:

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

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

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

The four broad data collection areas include:

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

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

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

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

A formal, combined mental health and substance abuse needs assessment committee consisting of members of the Governor-appointed Wisconsin Council on Mental Health and State Council on Alcohol

and Other Drug Abuse was established to provide guidance and direction about issues to examine, to review the analyzed data, provide a preliminary ranking of priorities, and assist with developing strategies and performance indicators. A tool based on a public health program priority rating model was developed to rate and rank the gaps, issues and problems identified through the Wisconsin needs assessment.

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

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

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

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

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M. Recovery

Narrative Question

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

Indicators/Measures

Please answer yes or no to the following questions:

- 1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery? YES
- 2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system? YES
- 3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care? YES
- 4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
- 5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
- 6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
- 7. Does the state have an accreditation program, certification program, or standards for peer-run services?
- 8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

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

- 1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
- 2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- 3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
- 4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

- 1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
- 2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Indicators/Measures

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

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

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

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

Yes, Wisconsin has three leadership roles held by individuals in recovery. Within its Bureau of Prevention Treatment and Recovery, Wisconsin employs a Consumer Affairs Coordinator, who is a person with lived experience and has a key role in policy-making and outreach to consumer stakeholders to elicit and increase meaningful participation. In addition, the Coordinator is a key staff to the two Governor appointed State Councils; the Wisconsin Council on Mental Health and the State Council on Alcohol and Other Drug Abuse. A new role for this position is that of contract administrator for the Statewide Consumer and Peer Support and Leadership Development grants, which provide financial support and technical assistance to eleven consumer operated recovery centers and the development of consumer leadership. The second recovery focused position is that of State Certified Peer Specialist Coordinator, who is also a person with lived experience. This position serves as a central point of contact with regard to all of the State's Certified Peer Specialist initiatives. The third position is the statewide program coordinator for the Alliance for Recovery Advocates and is also a person with lived experience from substance use disorder.

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

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

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

Yes, Wisconsin has utilized the Mental Health Block Grant to support eleven consumer operated recovery centers which deliver a variety of peer support, including a warm line, consumer/family education, and peer specialists. In addition, Wisconsin has created a Certification for Peer Specialist (CPS) services, that

when provided within a number of communities based psycho-social rehabilitation programs, are reimbursable by Medicaid. In addition to these programs, Wisconsin has promoted the use of CPS' and peer support within crisis services. Each county in Wisconsin is responsible for the provision of crisis services and have the ability to also provide and receive reimbursement for the provision of Crisis Stabilization Services that can be provided in a community based rehabilitation facility or individually based community services. Counties are able to employ and utilize CPS' in the provision of either crisis service. Wisconsin has supported training for Recovery Coaching to be used in the provision of substance use disorder treatment. At this time, Wisconsin is working to define core competencies for recovery coaches and explore implementation in community services and potential for reimbursement. Currently, Wisconsin has been exploring through research and stakeholder meetings, consumer operated crisis respite services. Wisconsin has funded and supported the adoption of Individual Placement and Services model of supported employment. Wisconsin received a grant from the J&J / Dartmouth Learning Collaborative and currently has six IPS sites, including a four county rural consortium.

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

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

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

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

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

Yes, Wisconsin does have an exam process for Certified Peer Specialists. Recently, the state began directly contracting with eleven peer-run recovery centers in 2013 which had previously utilized a fiscal agent in a sub-grantee agreement. Through this process, Wisconsin is contracting with a consumer operated agency, in conjunction with the Consumer Affair Coordinator; to work with each of the centers to collaborate and develop standards for block grant funded consumer-operated recovery centers. Recommendations for these benchmarks and a peer review system are expected to be finalized within the next two years.

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

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

Involvement of Individuals and Families

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wisconsin's Real Choice Systems Change Grant: Building Sustainable Partnerships for Housing. The Frank Melville Supportive Housing Act of 2011 revitalized and reformed the HUD Section 811 Supportive Housing for Persons with Disabilities Program. DHS and the Wisconsin Housing and Economic Development Authority (WHEDA) are partnering to plan implementation of the new HUD Section 811 program in Wisconsin. Led by the Bureau of Long Term Support in DHS and Housing Specialists within the "Money Follows the Person" program, it emphasizes community integration and relocation for persons with disabilities and frail elders who transition out of institutions. Members from community organizations, developers, healthcare providers and advocates are all part of this planning effort through the "housing workgroup."

As part of the thrust of the "Money Follows the Person" initiative in Wisconsin, goals of the project while focused on individuals in the Medicaid waiver system (those with disabilities and frail elders), also extend to those with disabilities who require supportive services in order to live in the community. Primarily efforts of the project are to: 1) create a new and sustainable relationship between DHS and WHEDA; 2) educate and provide technical assistance to developers about the benefits of the reformed Section 811 program and the clientele these projects can serve; 3) establish a new housing counseling curriculum to be used by provider agencies serving members in the community and to provide technical assistance during the implementation stage as well as on a case-by-case basis; 4) create a new independent housing referral process utilizing the current infrastructure of the long-term care system.

This new relationship between the Wisconsin Department of Health Services (DHS) and the Wisconsin Housing and Economic Development Authority (WHEDA), aims toward the goal of partnering together to develop new, high quality and integrated supportive housing units for Medicaid-eligible persons with disabilities. The grant period was extended by the Center for Medicaid and Medicare Services (CMS)

until September of 2013. Six trainings to nearly 400 individuals were provided in conjunction with Movin' Out, Inc. focusing on housing counseling and expanding affordable and accessible housing options for persons with disabilities. Moreover, the Tenant Resource Center assisted with marketing and outreach to landlords and consumers with an expanded Housing Law Seminar this past autumn. Moreover, a non-profit housing develop, Accessible Space, Inc. provided housing developer training in collaboration with WHEDA, DHS and Movin' Out, Inc. in December 2012. Nearly 20 developers were in attendance. WHEDA is also on board to assist with providing information to non-profit and for profit developers about the changes to HUD Section 811 and how the changes will affect future LIHTC applications and their relationship with supportive service providers.

Outreach to this point has consisted of training funded by the Real Choice Systems Change: Building Sustainable Partnerships in Housing grant. Attendees have included Aging and Disability Resource Center (ADRC) staff, Managed Care Organization (MCO) staff, county waiver agency staff, IRIS staff and participants (and their family members), Independent Living Center staff, support service providers, landlords and housing authorities.

Through the Section 811 Notice of Funding Availability (NOFA), in August 2012 an application was submitted for $3,013,154 to fund approximately 300 units over a five year period (60 units per year). The focus population for these spots under Section 811 currently stands as follows: 1) Those eligible persons currently residing in institutions or nursing homes, who may also qualify for the "Money Follows the Person" program; and 2) Those eligible persons who may be at risk of institutionalization, who currently live in substandard housing or who are not living where or with whom they choose.

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

N. Prevention

Narrative Question:

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

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

States should provide responses to the following questions:

- 1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
- 2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
- 3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
- 4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
- 5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

- 6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
- 7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Primary Prevention Services Needed

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

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

Primary Prevention Programs and Methods

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

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

Prevention System and Workforce Capacity Building
Wisconsin DHS provides funds to the Wisconsin Clearinghouse for Prevention Resources for the development, and provision of an annual statewide Prevention Conference. This conference brings together prevention professionals from around the state to share ideas, gain knowledge related to substance abuse prevention and network with other providers. By attending this conference, attendees receive Continuing Education Units towards their Prevention Specialist certification.

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

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

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

Prevention Strategy Outcome Data Collection
The Wisconsin DHS collects outcome data through national (NSDUH, BRFSS, NHTSA) and state reports (YRBS, OJA). These findings are reported every two years in the State Epidemiological Profile. The profile tracks trend data in substance abuse and provides the state the ability to identify needs for ongoing services.

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

Strategic Prevention Framework
Wisconsin DHS has institutionalized the Strategic Prevention Framework by:

- Producing a State Epidemiological Profile every two years to identify statewide priorities around substance abuse (Assessment);
- Providing SAPST training, an annual prevention conference and Prevention Regional Center support to local coalitions (Capacity building);
- Supporting and staffing the State Council on Alcohol and Other Drug Abuse (SCAODA) and its sub-committees in the development of a four-year strategic plan and budget initiatives (Strategic Planning);

- Funding counties, tribes and community groups to provide prevention services (Implementation); and
- Monitoring the use of prevention funds through the Substance Abuse Prevention Services Information System (SAP-SIS) for programmatic quality improvement purposes (Evaluation).

O. Children and Adolescents Behavioral Health Services

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

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

Please answer the following questions:
1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

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

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

In 2009, the ISP legislation was revised through Act 334. Some updates were made to the legislation including expansion of the target population to children who are being served by two or more service systems, permitting children and youth with substance use disorders access to the team process. In addition, the name of the initiative was changed to the Coordinated Services Team (CST) Initiative. The legislation continues to require that the Department of Health Services (DHS) provide funding for this initiative (grants and technical assistance/ training) from the Mental Health Block Grant (MHBG). However, the state has in fact identified other revenue sources that also fund the program. In addition, the Governor was proposed for his 2014-2016 state budget to expand CST statewide.

Currently, this initiative is at a crossroads: all 72 counties and 11 Native American tribes have been offered the opportunity to compete for grant funds (for generally a five year period). There are several policy decisions that must be made related to the new legislation, as such the Bureau of Prevention Treatment and Recovery, in collaboration with the Children Come First Advisory Council (mandated by the CST legislation), will be evaluating the current program and developing a plan for the next generation of Coordinated Service Teams.

Lastly, staff of the Children Youth and Families Unit of the BPTR monitor and administer the grants. Recently the Unit received permission to hire a halftime person who, among other duties, will be responsible for reviewing the Unit's current monitoring and oversight practices and making recommendations to improve them.

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

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

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

- Staff from the Unit staffs the Children, Youth, and Families Subcommittee of the Wisconsin Mental Health Council. This committee meets monthly and the membership adheres to the requirements for the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Planning Council.
- Staff from the Unit also staffs the Children Come First Advisory Council to the CST's. This committee meets quarterly. Membership is mandated by State Statute and includes parents of

children, child welfare, juvenile justice, public schools, higher education, private providers, and vocational rehabilitation.

- The Children Youth and Families Unit has a full time staff member who spends all her time helping agencies implement a Trauma Informed Care environment. While this effort is across the life span, she has worked with a number of child serving programs. In addition she collaborates with the Department of Public Instruction in their Trauma Sensitive Schools Initiative, and with a number of stakeholders in the Wisconsin Adverse Childhood Experiences Initiative.
- The Transformation Transfer Initiative is an activity funded by SAMHSA that involves DHS, the Department of Corrections Juvenile Justice Division and the Statewide Parent Advocacy agency, Wisconsin Family Ties. The initiative is developing a trauma informed care environment in one cottage at the juvenile corrections facility.
- Staff from the Unit staffs the Parent Peer Specialist Planning group that is developing guidelines for both mental health and substance abuse Parent Peer Specialists and a certification process. This group meets monthly and includes numerous representatives from the mental health and substance abuse communities.

Training in Evidence Based Practices

Currently the Children Youth and Families Unit has two vacancies. One is for an Adolescent Treatment Coordinator specializing in substance use and co-occurring disorder. The person previously in this position was very effective in disseminating information on several Evidence Based Practices (EBP's) for adolescents. We will be requesting permission to hire a replacement for this position in the near future, and if such permission is granted will include EBP dissemination and training in the Position Description. Hiring of the second position has been approved and the position description indicates that this person will be responsible for developing a clearinghouse for EBP's for children and youth.

Monitoring and Tracking Service Utilization, Costs and Outcomes

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

In addition, the legislation requires that the Department of Health Services evaluate the initiative addressing the following:

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

6. Types of services provided to children and their families through the initiative and the cost of these services.
7. A systems change plan and sustainability plan.

This evaluation is conducted every year by BPTR evaluators and the results are included in a CST Annual Report. The analysis of this data is a crucial component of our oversight/monitoring activities. Counties have been very successful in demonstrating the use of CST's to reduce costs in getting support and funding for CST's. The Advisory Council has been discussing ways that we can even do better in demonstrating cost efficiency, effectiveness and positive outcomes and as previously indicated, the Unit will also be working on improving its oversight activities.

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P. Consultation with Tribes

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

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

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

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

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

- On July 26 and August 9 2012 DHS-DMHSAS hosted meetings for Tribal Nations on the block grants. The July 26 meeting focused on an orientation to the block grants, how the

funding is currently used in WI, and the amount of block grant funding allocated to Tribal programs. The Aug 9 meeting focused on the block grant needs assessment, each Tribe was asked to identify recommendations for mental health and substance abuse services based on the unique needs of tribal populations. Nine of the eleven tribes in WI participated in these events.

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

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

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

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

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Q. Data and Information Technology

Narrative Question:

- In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:
- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Information Technology Systems

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

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

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

Mental health client functional status data is collected only for children with severe emotional disturbances (SED) and adults with a serious mental illness (SMI). Twelve functional status data elements are collected including living arrangement, employment status, daily activities, criminal justice system involvement, suicide risk, and health status. Consumer functional status data is collected at

admission and then every six months for as long as consumers are receiving services. Substance abuse client functional status data is collected for only for people who need more than brief services. For these clients, functional status data is collected at enrollment and discharge. The data collected includes living arrangement, employment status, criminal justice system involvement, support group attendance, and substance use frequency.

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

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

Client-Level Data Capacity

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

For these reasons, Wisconsin is in the process of replacing HSRS with a new database (called PPS) having two methods of data submission for local reporting agencies. The first data submission method is a set of web-based data entry screens that reporting agencies can use to key their data if they don't have their own local information system. Small, rural counties are most likely to use this method to submit their data to the State. This web-based direct data entry system will allow counties to record services at a detailed encounter level and will also have a page dedicated to mental health consumer outcomes

including the NOMS. The outcome measures will be updated by providers every six months as long as a consumer is receiving services. Most of the 2011 mental health DIG funds and SOMMS funds have been spent to design and test this system. The PPS web data system was released for county provider use in June, 2012. The release marks the beginning of Phase 1 of the process which includes the implementation of the new information technology and the current HSRS data system elements. The new CMHS-required NOMS (school attendance, grade level, and 30-day arrests) are scheduled to be implemented into the new data system in Phase 2 in 2013. The official release of the new NOMS by CMHS in late October 2011 was too late for Wisconsin to incorporate into Phase 1 of its new data system. Thus, the new measures will be implemented in the data system in 2013 and collected by county providers in 2013.

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

Electronic Health Records (EHR)

Wisconsin has designed its previously described PPS data system similar to an electronic health record. It has a unique enrollment process and client numbering system, screens that resemble an electronic health record, individual search and record management functionality, and, in general, the basis for each record is the individual client. Individual client records can be printed but also aggregate reports on service utilization and outcomes can be accessed. The system will adhere to HIPAA and other related federal EHR requirements. The Wisconsin Division of Mental Health and Substance Abuse Services is also promoting local agency adoption of electronic health record and practice management systems through small innovation and quality improvement projects.

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

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

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

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

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

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

Barriers to Implementing Encounter-Based Claims Systems
The State Division of Mental Health and Substance Abuse Services (DMHSAS) is both the State Mental Health Authority (SMHA) and Single State Authority for substance abuse (SSA). Since Wisconsin has a state-administered, county-operated service system, funding is mostly distributed in the form of competitive grants and grants-in-aid to local County agencies based upon a formula approved by the Legislature. Neither the SMHA nor SSA utilize a claims-based approach to funding sources. However, if the SMHA/SSA were to implement an encounter-based claims system, it could easily modify PPS and draw on the existing Medicaid data system technology for this purpose.

Technical Assistance Needed
No technical assistance is needed by Wisconsin at this time in the area of data and information technology.

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R. Quality Improvement Plan

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

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

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

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

The collection and measurement of indicators reflecting the performance outcomes -- and fidelity to -- various evidence-based practices and programs remains a challenge for DMHSAS. The Division of Quality Assurance within the WI Department of Health Services provides periodic site visit surveys of programs for compliance with state law and administrative codes. That Division, however, does not have authority to evaluate adherence to evidence-based practices in certified programs.

Recently, DMHSAS hired additional contract specialists to coordinate Division efforts to improve the contract-making process and to promote easier, more efficient sharing of contract process, fiscal, and performance outcome information among Division staff, counties, vendors and other service providers. Part of these new efforts include improving the use of existing database system; interfacing data from those systems with online information management platforms (such as Microsoft Office's SharePoint) to enable more expeditious sharing of RFPs and submissions, contracts, performance reports; cataloging the many different performance measures and performance/progress reports utilized by DMHSAS; and training Division staff on effective use of these database systems and information platforms. These initiatives are designed to improve the Division's capacity to develop relevant and meaningful outcomes and performance indicators, track progress and accomplishments of numerous contract projects, and make reliable, valid findings relative to the effectiveness of project services and their impact on the mental health and substance abuse needs of clients.

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

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

In addition, the CRO staff includes the State Grievance Examiner, who is responsible for conducting Level III grievances. The CRO also consults with and coordinates training activities for service providers, county agencies, department staff, clients and guardians regarding client rights and DHS 94 grievance resolution procedures.

S. Suicide Prevention

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

•Provide the most recent copy of your state's suicide prevention plan; or

•Describe when your state will create or update your plan.

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

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

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

MHA staff continues to provide training and technical assistance to local suicide prevention coalitions. Twelve counties were provided technical assistance or participated for the first time in PSW activities this year. Representatives from 36 Wisconsin counties participated in the annual conference. Mini-grants were

awarded to six communities to support public awareness and community education during or around Suicide Prevention Awareness Week in September.

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

MHA provided over 70 additional trainings and educational events to school groups, employers, church groups, health care providers and other organizations reaching over 2000 individuals. MHA staffs also were present at a variety of health fairs and conferences including the NAMI Conference, the Wisconsin Psychiatric Association annual meeting, the Crisis Intervention Conference, the Wisconsin Institute for Healthy Aging Prevention Summit, the Boys and Girls At Risk conference. This second annual Communities in Action to Prevent Suicide Conference drew 160 attendees, up significantly from the prior year. Breakouts included LGBT youth issues, veterans issues, law enforcement training, faith-based suicide prevention, survivor support and coalition discussions. On a scale of 1-5 with 1 being "strongly agree" attendees rated the following statement a 1.7: "overall the conference was extremely valuable to me and to suicide prevention in my area."

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

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

Other MHA activities in FFY2012 included:

- Coordination with the Wisconsin Prevention Network, Wisconsin United for Mental Health (WUMH), the statewide Crisis Network and other mental health consumer and family advocacy groups.
- Collaboration with Kenosha County on their grant from the Medical College of Wisconsin and their successful application for continued funding to support suicide prevention.
- Successful completion of a development grant from the Wisconsin Partnership Program at the University of Wisconsin School of Medicine and Public Health to create a strategic plan for workplace mental health practices.

- Completion of an American Sign Language adaptation of the SOS video with Wisconsin School for the Deaf and participation with the Wisconsin Office of the Deaf and Hard of Hearing on development and implementation of a statewide summit on mental health and substance use disorder services for the deaf, deaf-blind, and hard of hearing.
- Continued work with the Department of Children and Families (DCF), the Department of Public Instruction (DPI) and the Department of Health Services (DHS) on an MOU for local agencies coordinating suicide prevention across child welfare, schools and human services.

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

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T. Use of Technology

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

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

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

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

Number of MH/AODA TeleHealth Certifications 2012

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

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

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

Community Recovery Services (CRS) is developing technological innovations to speed consumer service plan processing time, and disseminate new and useful information to stakeholders. CRS is using internet-based posting and a list-serve to keep steady communications with CRS sites. In addition, Adobe Connect is used to bring CRS teams together via remote online meetings. Most recently, the latest initiative involved the creation of an electronic case file (ECF) for all CRS consumer records. Integral to

this initiative is a procedure by which counties and tribes are encouraged to submit an entire consumer service plan packet electronically via the State's newly implemented encrypted email system. The ECF exists on the secure internal computer system of the Department. The CRS Team is creating both policy and procedure to address issues such as record retention, HIPAA/HITECH compliance, cataloging, and work-in-process. ECF will be accessible by all CRS Team members simultaneously, and will also be accessible from remote locations via the Department of Health Services' (DHS) secure virtual private network (VPN). Adobe Acrobat technology allows physical files to be scanned into an electronic format. Submission of consumer service plans via the State's encrypted email system is expected to be a very valuable and popular procedure for Wisconsin's counties and tribes. Encrypted email is deemed to be both HIPAA and HITECH compliant, and the labor and cost savings related to the management and retention of physical records is expected to be significant over the lifetime of the benefit.

The results of a recent Request for Interest regarding a possible new pilot project found that the top request was for pilots in the area of integration of behavioral health and primary care. The Bureau of Pretention, Treatment and Recovery (BPTR) will be working with the County Infrastructure Group to develop future plans in this area.

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

Budget cuts and staff vacancies may be a barrier to implementing large scale new interactive technologies that require a sizable fiscal investment upfront. Smaller changes, such as those underway, may provide fiscal relief via reduced staff travel costs.

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

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

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

1. Establish the eHealth technology platform.

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

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

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

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

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

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

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U. Technical Assistance Needs

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

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

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

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

V. Support of State Partners

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

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

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W. State Behavioral Health Advisory Council

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

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

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

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

The State of Wisconsin has two behavioral health advisory councils the Wisconsin Council on Mental Health (WCMH) and the State Council on Alcohol and Other Drug Abuse (SCAODA). Both councils are Governor appointed.

The WCMH is legislatively mandated under section15.197 (1), Wisconsin Statutes, as the mental health planning Council for the State. It was created to advise the Governor, the Legislature and the Department

of Health Services (DHS) on the allocation of Mental Health Block Grant funds. The Council has 20 to 25 members appointed by the Governor, meeting bi-monthly. At least 50 percent of the members are consumers and/or family members. Other members represent state agencies, mental health providers, and other organizations or groups. Currently the Council has 17 members 10 of which are not state employees or providers. Of these 10 four are advocates, three are consumers, and three are parents. The other members of the council are a provider of mental health services, a single representative from each of the following state agencies: education, housing, Medicaid, mental health, social services, and vocational rehabilitation. New appointments to the committee are expected in early July of 2013 to ensure an adequate level of council membership is achieved.

The WCMH has several duties and responsibilities as specified in section 51.02, Wisconsin Statutes. The Council evaluates and reviews the mental health system's progress towards achieving improved client outcomes and the adequacy of mental health services in the State. The Council oversees state compliance with federal Public Law 102-321. In addition, the Council participates in developing, monitoring, and evaluating the implementation of the Mental Health Block Grant Plan for adults and children. Other duties include the review all DHS plans for services affecting persons with mental illness and monitor the implementation of the plans, and to serve as an advocate for persons of all ages with mental illness. The Council operates six committees: the Executive Council Committee, the Adult Quality Committee, the Children and Youth Committee, the Criminal Justice Committee, the Legislative and Policy Committee, and the Nominating Committee.

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

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

The WCMH and the SCOADA both were both involved in the development of Wisconsin's Block Grant plan. Efforts began in early April 2012 to conduct a needs assessment of the mental health and substance abuse needs of Wisconsin. A collaborative committee of representatives from the WCMH, SCAODA, and the Wisconsin DHS was formed. This group became the Ad Hoc Needs Assessment Committee, and was tasked with planning and developing a needs assessment. This needs assessment would act as a standalone tool for the state's mental health and substance abuse services and inform Wisconsin's block

grant application. Throughout 2012 the Ad Hoc Needs Assessment Committee convened one to two times a month to discuss plans and develop the needs assessment.

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

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

The WCMH and the SCAODA also provided input and critique of the Block Grant plan. In February and March of 2013, prior to final approval by DHS, the Block Grant plan was provided to the WCMH and the SCOADA committees. After committee evaluation and comment, the Block Grant plan was provided to the WCMH and the SCAODA. Each council and committee provided feedback and critique of the plan. After this review each council approved the Wisconsin Block Grant Plan. (Note: This section will revised as the block grant review process is completed.)

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IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Page 89 of the Application Guidance

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	**25**	
Individuals in Recovery	3	
Family Members of Individuals in Recovery	2	
Parents of children with SED	1	
Vacancies (Individuals and Family Members)	6	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	**14**	**56%**
State Employees	7	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	3	
Total State Employees & Providers	**11**	**44%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	**0%**
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

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

Footnotes:

X. Comment on the State BG Plan

Narrative Question:

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

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Appendix 2

Service	Covered by Medicaid*	Covered by QHP**
Healthcare Home/Physical Health		
General and specialized outpatient medical services	X	X
Acute Primary care	X	X
General Health Screens, Tests and Immunizations	X	X
Comprehensive Care Management - Targeted CM	X*	
Care coordination and Health Promotion	X*	
Comprehensive Transitional Care	X	X
Individual and Family Support		
Referral to Community Services Dissemination		
Engagement Services		
Assessment	X	X
Specialized Evaluations (Psychological and Neurological)	X	X
Service Planning (including crisis planning)	X	
Consumer/Family Education	X *	
Outreach		
Outpatient Services		
Individual evidenced based therapies	X	X
Group therapy	X	X

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Family therapy	X	
Multi-family therapy		
Consultation to Caregivers		
Medication Services		
Medication management	X	X
Pharmacotherapy (including MAT)	X	
Laboratory services	X	X
Community Support (Rehabilitative)		
Parent/Caregiver Support		
Skill building (social, daily living, cognitive)	X*	
Case management	X*	
Behavior management	X*	
Supported employment	X*	
Permanent supported housing		
Recovery housing		
Therapeutic mentoring		
Traditional healing services		
Recovery Supports		
Peer Support	X*	
Recovery Support Coaching	X*	

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Recovery Support Center Services		
Supports for Self Directed Care		
Other Supports (Habilitative)		
Personal Care	X	
Homemaker		
Respite		
Supported Education		
Transportation	X	
Assisted living services	X*	
Recreational services		
Trained behavioral health interpreters		
Interactive communication technology devices		
Intensive Support Services		
Substance abuse intensive outpatient (IOP)	X	X
Partial hospital	X	X
Assertive Community Treatment	X*	
Intensive home based services	X*	
Multi-systemic therapy		
Intensive Case Management	X*	
Out-of-Home Residential Services		

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Crisis residential/stabilization	X	
Clinically Managed 24 Hour Care (SA)	X*	X
Clinically Managed Medium Intensity Care (SA)	X	X
Adult Mental Health Residential	X*	
Youth Substance Abuse Residential Services	X*	
Children's Mental Health Residential Services	X*	
Therapeutic foster care		
Acute Intensive Services		
Mobile crisis services	X	
Peer based crisis services		
Urgent care services	X	X
23 hour crisis stabilization services	X*	X
Medically Monitored Intensive Inpatient (SA)	X*	X
24/7 crisis hotline services	X	X
Prevention (Including Promotion)		
Screening, Brief Intervention and Referral to Treatment	X	
Brief Motivational Interviews	X	
Screening and Brief Intervention for Tobacco Cessation	X	
Parent Training		
Facilitated Referrals		

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Relapse Prevention/Wellness Recovery Support	X*	
Warm Line		
System improvement activities		
Other		

Footnotes:

* Some Medicaid funded benefits are available to individuals based on severity of need, for certain target populations or for individuals enrolled in specialized Medicaid benefit programs.

** Awaiting further information from DHHS on coverage of any additional Behavioral Health services.

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