Wisconsin DRAFT Application and Plan for the Combined Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) and Community Mental Health Services Block Grant (MHBG)

Federal Fiscal Year 2026

The following document is a draft of the bi-annual combined application for the 2026 MHBG and SUPTRS for Wisconsin. This draft is intended as a first version to solicit feedback and input from the public and members of advisory councils and committees. This application and plan may change from this version prior to being submitted to the Substance Use and Mental Health Services Administration (SAMHSA) on September 1, 2025.

Any public comment and/or feedback can be directed to Alison Elisius (SUBG Planner and Coordinator) and Hannah Foley (MHBG Planner and Coordinator) within the Bureau of Prevention Treatment and Recovery at alison.elisis@dhs.wisconsin.gov and hannah.foley@dhs.wisconsin.gov.

DRAFT August 19, 2025

Wisconsin

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/19/2025 12.23.25 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	CG2SZ7HCNV54

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Department of Health Services
Organizational Unit	Division of Care and Treatment Services, Bureau of Prevention Treatment and Recovery
Mailing Address	200 E. Washington Avenue, GEF1
City	Madison
Zip Code	53707

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Joanette
Last Name	Robertson
Agency Name	WI Department of Health Services, Division of Care and Treatment Services
Mailing Address	200 E. Washington Avenue, GEF1
City	Madison
Zip Code	53707
Telephone	608-266-0907
Fax	
Email Address	Joanette.Robertson@dhs.wisconsin.gov

State CMHS Unique Entity Identification

Unique Entity ID	CG2SZ7HCNV54

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

Agency Name	Department of Health Services
Organizational Unit	Division of Care and Treatment Services; Bureau of Prevention Treatment and Recovery
Mailing Address	200 E. Washington Avenue, GEF1
City	Madison
Zip Code	53707

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

First Name	Joanette
Last Name	Robertson
Agency Name	Department of Health Services, Division of Care and Treatment Services
Mailing Address	200 E. Washington Avenue, GEF1
City	Madison
Zip Code	53707
Telephone	608-266-0907
Fax	
Email Address	Joanette.Robertson@dhs.wisconsin.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name	Hannah
Last Name	Foley
Telephone	608-261-8334
Fax	
Email Address	hannah.foley@dhs.wisconsin.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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Fiscal Year 2026

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Wisconsin has a state-supervised, county-based mental health and substance use disorder (MH/SUD) system. The Division of Care and Treatment Services (DCTS) in the Department of Health Services (DHS) is the designated State Mental Health Authority (SMHA) and Single State Agency (SSA) for SUD. DCTS is responsible for allocating state and federal funding for the provision of MH/SUD services and for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities, and Mental Health Act, Wis. Stat. Ch. 51. While the state has broad responsibility for MH/SUD system planning, management, and oversight, the counties are statutorily responsible for administering MH/SUD services. Counties may meet the MH/SUD service responsibility through single county systems, such as single county boards and departments of community programs or human services, or through multi-county systems. Counties are responsible for providing services for both child and adult systems.

Wisconsin utilizes a collaborative approach to ensure the monitoring of MH/SUD prevention and treatment services through regionally based department staff, county-based alcohol and other drug use service coordinators, and contract administrators within DCTS. Wisconsin's regions include Northeastern, Northern, Southeastern, Southern, and Western and are comprised of the 72 counties and 11 federally recognized Native American Tribal nations. DCTS staff conducts site visits to provider entities to review progress and offer technical assistance as necessary.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

Wisconsin has a state-supervised, county-based MH/SUD system. The Division of Care and Treatment Services (DCTS) in DHS is the designated SMHA. DCTS is responsible for allocating state and federal funding for the provision of MH/SUD services and for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities, and Mental Health Act, Wisconsin Statutes Chapter 51. While the state has broad responsibility for M. H/SUD system planning, management, and oversight, the counties are statutorily responsible for administering MH/SUD services. There are two bureaus in DCTS—the Bureau of Community Forensic Services (BCFS) and the Bureau of Prevention Treatment and Recovery (BPTR).

BPTR oversees, supports, and funds Wisconsin's community-based health and human services providers. These agencies provide MH/SUD programs for adults and children, crisis intervention, prevention services, peer-based services, and inpatient treatment. The focus is on client-centered and recovery-oriented practices. BCFS promotes healthy living and protects public safety through the management and support of programs for adults with histories of criminal offenses and MH/SUD concerns. DCTS promotes overall wellness through the management and support of community MH/SUD services for people of all ages and backgrounds. Wisconsin DHS uses regional staff, the Division of Quality Assurance (DQA), and DCTS contract administrators to monitor services in the state. DCTS also has a Client Rights Office, Communications Team, Office of Budget and Performance Management, and Office of Electronic Health Records. DCTS works closely and collaboratively with other state agencies that serve specific populations to ensure that MH/SUD services are available and accessible. These agencies include Department of Children and Families; Department of Veteran's Affairs; Department of Corrections; Department of Safety and Professional Services; and Department of Agriculture, Trade, and Consumer Protection.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

As noted above, county MH/SUD 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 MH/SUD services for public consumers. The largest source of federal funds for the provision of MH services is through the Medicaid program. In Wisconsin most MH Medicaid recipients are served through the Badger Care and SSI 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. In addition, Wisconsin implemented SUD residential treatment services in 2021. Also, state general purpose revenue funds have been utilized to fund several regional opioid treatment centers. DHS also uses other federal grant awards – including Prescription Drug/Opioid Overdose-Related Deaths Prevention Project and State Opioid Response – to address SUD needs.

Psychiatric Hospitalization

When psychiatric hospitalization is required in Wisconsin it occurs in one of the following five settings: state MH institutions, county MH hospitals, veteran's administration hospitals, private psychiatric hospitals, and general medical/surgical hospitals. DCTS has administrative management of the two state MH 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 MH 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 MH services to some of its supervisees.

The Wisconsin public MH system emphasizes the importance of treatment services being available at the community level in the least restrictive environment. The community MH system strives to provide an array of services to consumers 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 MH 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 Use Disorder Prevention and Treatment Services

Wis. Stat. §51.001 provides that Wisconsin shall provide a full range of prevention, treatment, and rehabilitation services for alcohol and other drug abuse, in a manner that ensures continuity of care within the limits of available state, federal, and county funds. Wis. Stat. §51.03 empowers DHS to promote fiscal stewardship in the provision of SUD services and to ensure that service providers develop, maintain, and evaluate their plans to address SUD need.

Counties are responsible for developing and managing a system of care for persons with SUDs (Wis. Stat. §51.42). This includes preparing short- and long-range plans to address SUD treatment needs, maintaining oversight of the planning process, and maintaining an inventory of existing resources. Counties are required to report the National Outcomes Measures (NOMS) data through Wisconsin's Program Participation System (PPS), which populates the Treatment Episode Data Set (TEDS), and through the Substance Abuse Prevention Service Information System (SAP-SIS) via a contract with DHS.

Direct grants awarded by DHS to private, non-profit, and county agencies are subject to performance management. Direct grant agencies are required to set performance objectives and report on progress on a semi-annual basis. DCTS 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 site visits to provider agencies to ensure programmatic and fiscal compliance and offer technical assistance as necessary.

An important change in 2021 was a new residential SUD treatment benefit effective February 1, 2021, to provide access to this needed level of care for members covered by Medicaid. The residential SUD benefit is available in medically monitored treatment (minimum of 20 hours of treatment services per week) and transitional treatment (minimum of 6 hours per week treatment services) facilities certified in Wisconsin under Wis. Admin. Code §§ DHS 75.11 and 75.14. The residential SUD treatment benefit was developed under a Section 1115 demonstration waiver and allows Wisconsin Medicaid to claim federal funding for residential SUD services provided in both community settings as well as Institutions for Mental Disease (IMDs) (or settings with more than 16 beds). At this time, many residential providers have applied for and have been approved as Medicaid providers, prior authorizations have been submitted and approved, and individuals are accessing residential care through this new benefit.

In October 2022, the revised Wis. Admin Code ch. DHS 75 was promulgated. This revised administrative rule sets the minimum standards for SUD prevention, intervention, and treatment services delivered across a variety of settings and levels of care. The revised Wis. Admin Code ch. DHS 75 is the product of years of partner and provider engagement and advocacy to ensure that DHS administrative rules reflect evidence-based practices and support advancement in patient care. This revised Wis. Admin. Code ch. DHS 75 puts the health and well-being of people receiving services for SUD first while easing provider requirements to support greater access to SUD services throughout the state.

Medication Assisted Treatment (MAT), including Medication for Opioid Use Disorder (MOUD), must be available to members who require it. Residential SUD treatment providers must provide MAT medication on site or enable access to the medication off-site and may not deny services to someone receiving MAT. Physicians and other qualified health professionals who perform psychiatric

evaluation and management services, which may include psychotherapy performed with an evaluation and management service, may be reimbursed separately from the daily rate.

Prevention and Intervention Services

Community Aids

Funds from the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) are distributed to counties through community aids as a categorical formula allocation. Counties are required to spend these funds on eligible SUD services, including a minimum of 20 percent on primary prevention services, and minimum of 10 percent on women's treatment services. Services are delivered either directly through one of the state's county-administered human service agencies or via a sub-contract with a local provider.

Brighter Futures Initiative

DHS provides funding to the Wisconsin Department of Children and Families to support the Brighter Futures Initiative (BFI). BFI promotes healthy families and youth; school success for youth; youth safety in their families and communities; and successful navigation from adolescence to adulthood. The Initiative supports evidence-based prevention strategies and a positive youth development approach.

Milwaukee Child Protection Services Substance Abuse Services

DHS provides funding to the Department of Children and Families to provide SUD intervention, prevention, treatment, and recovery services to families involved in Milwaukee County Child Protective Services and child welfare.

Alliance for Wisconsin Youth Regional Prevention Centers

The Alliance for Wisconsin Youth (AWY) brings together coalitions, individuals, and resources to promote positive youth development, including the prevention of SUD and behavioral health concerns. DHS funds Wisconsin's five regional prevention centers administered by three private vendors. The centers work with local community coalitions to build capacity for the delivery of effective SUD prevention strategies at the local level.

Building Prevention Workforce Capacity

DHS provides Substance Abuse Prevention Specialist Training across the state to enhance the capacity of the prevention workforce to effectively serve communities.

Urban Youth Primary Substance Use Prevention

DHS funds primary SUD prevention services for youth in grades K-12 in urban areas.

Injection Drug Use Prevention

Wisconsin devotes SUPTRS BG funds to support injection drug use prevention efforts and street outreach. In addition, block grant funds are provided to DHS, Division of Public Health to support various outreach and educational activities for persons who inject drugs.

Youth SU Prevention Services

SUPTRS BG funds are awarded to the WI Department of Justice to provide education and prevention services to youth who are at-risk of alcohol and drug abuse as well and to their family members.

Statewide Prevention Policies and Strategies

DHS partners with the University of Wisconsin (UW) to educate municipalities on alcohol policy and prevention strategies. SUPTRS BG funds are also used to support a prevention specialist to assist with program delivery and evaluation.

Program Evaluation

Entities receiving SUPTRS BG funds for primary prevention activities are required to report annually into the Substance Abuse Prevention Services Information System (SAP-SIS). The required information includes the NOMs data, description of the services provided, and program expenses.

Treatment Services

An array of SUD treatment services is available to Wisconsin's residents. These services include inpatient, detoxification-medically managed, detoxification, medically monitored or residential, residential primary-short term and residential transitional-long term, day treatment, outpatient-intensive, outpatient-regular, and case management. In addition to these local services, DHS funds more specialized treatment programs, as set forth below.

Women's Treatment Services

SUPTRS BG funds are distributed to counties through community aids as a categorical formula allocation. Counties are required to spend these funds on eligible SUD services, including a minimum of 10 percent on women's services. Services are delivered either directly through one of the state's county-administered human service agencies or via a sub-contract with a local provider. In addition, grant funds are distributed to counties, tribes, and local providers under Women's SU Treatment, Urban/Rural Women's Treatment, and Milwaukee Family-Centered Treatment programs.

Injection Drug Use Treatment
Under this program, grant funds support treatment needs for people who inject drugs in four counties and across the state through a contract with Vivent Health, previously the AIDS Resource Center of WI (ARCW), Inc.

Coordinated Services Team (CST) Initiatives
CST is designed to develop coordinated systems of care for children and adolescents with Severe Emotional Disorder (SED), and their families who require support from multiple community-based agencies. Under the CST initiative a county or tribe is to establish a strength-based system of care that supports children and adolescents, along with their families, to address MH, SUD juvenile justice, and/or child welfare needs. State General Purpose Revenue (GPR), MHBG, and SUPTRS BG collectively fund this service. Currently, 67 counties and 10 federally recognized Tribal nations in Wisconsin participate in the CST Initiative. Additionally, Dane and Milwaukee counties offer a managed care model of this service.

Integrated Peer Specialist Training and Certification
Both SUPTRS BG and MHBG funds are used to support the development of certification curricula and the certification and training of Peer Specialists. Wisconsin has implemented an integrated model for peer specialists, including training and certification to serve people with lived experiences in MH/SUD.

Parent Peer Specialist Training and Certification
MHBG funds are used to support the development of certification curricula, certification, and training of Parent Peer Specialists. Parent Peer Specialists utilize their knowledge gained from parenting children and youth with MH/SU needs in combination with their training to guide and support other parents or those in a parenting role.

Methamphetamine Treatment
DHS currently funds four counties to provide intensive outpatient MATRIX and other evidence-based practices in treatment for methamphetamine use for county residents who are struggling with drug use.

Department of Corrections SU Treatment
DHS funds various programs within the Department of Corrections, including alcohol and drug use treatment for adolescent residents in the juvenile correctional facilities, female residents in adult corrections, treatment and support for females enrolled in halfway houses, and other persons on probation and parole.

Milwaukee Child Protection Services Substance Abuse Services
DHS provides funding to the Wisconsin Department of Children and Families to provide SUD services to Milwaukee County youth and family members.

Youth Justice Screening and Diversion
DHS funds multi-disciplinary screening and diversion efforts that counties and service providers use to identify youth at-risk for SUD and to implement early intervention strategies.

Treatment Alternative Program (TAP)
The TAP provides an alternative to incarceration for people with SUDs. Screening and assessment services are provided to develop an individualized treatment plan using a wraparound approach.

Treatment Alternatives and Diversion (TAD)
The TAD program provides alternatives to prosecution and/or incarceration for criminal offenders with SUDs.

Voices for Recovery and Trauma-Informed Care
DHS contracts with the UW-Madison to provide training and technical support to increase the number and reach of recovery coach organizations to offer peer support services by recovery coaches and/or certified peer support specialists, enhance professional SUD workers' and providers' knowledge about fighting stigma, and provide information on recovery, trauma-informed care-based themes, and best practices.

Problem-Solving Courts
Wisconsin has over 60 problem-solving courts, including adult drug treatment courts, operating while intoxicated courts, juvenile drug treatment courts, and family dependency courts. These courts provide an alternative to traditional court for those with SUDs.

Opioid Treatment Programs/Medication-Assisted Treatment
Wisconsin currently has 25 opioid treatment programs that use medication-assisted treatment. Wisconsin utilized General Purpose Revenue, Opioid Settlement, and State Opioid Response Grant funding to develop and implement a total of 12 mobile opioid treatment program units (four units in 2022 and eight in 2023). These mobile units are focused on increasing access to MAT to communities in rural and high-risk areas. Each unit is designed to dispense all three forms of FDA-approved MOUD and clinical services. The first mobile OTP was deployed for services in early August 2023.

Statewide Training, Conferences and Technical Assistance
DHS is currently partnering with UW-Milwaukee, School of Social Welfare, and the Center for Urban Population Health to conduct

training needs assessments, and from those findings coordinate training, conferences, and technical assistance activities focusing on a wide array of best practice programming strategies and models.

Helpline and Hotline Assistance
In addition, DHS partners with other state agencies and the UW to support two resources, one to assist persons with SUD treatment and recovery needs, and the other to assist medication-assisted treatment and other providers. These two resources are the Wisconsin Addiction Recovery Helpline and the Addiction Consultation Provider Hotline.

Behavioral Health Services
A continuum of services has been developed to meet the needs of persons with mental illness and SUDs in Wisconsin. Originally a large divide existed between MH/SUD 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. The DCTS continues to work to better integrate MH/SU services and integration remains a strategic focus. One of the primary services utilized in Wisconsin is the outpatient MH program. This program is designed as a Medicaid reimbursed clinic where a person can receive services from a psychotherapist, psychiatrist, nurse prescriber, or nurse practitioner.

Comprehensive Community Services (CCS)
CCS provides psychosocial rehabilitation services to people of all ages (youth to elderly) living with either a mental illness and/or SUD. CCS is for individuals who need ongoing services beyond occasional outpatient care, but less than the intensive care provided in a Community Support Program (see below). CCS utilizes an advisory committee which consists of members from those county or tribal human services departments involved, economic support agencies involved in CCS eligibility, administration and provider certification, child welfare, providers, and consumers. As committee members, the providers and interested parties can provide feedback to the CCS program regarding policies, practices, and procedures that are recovery-oriented and person-centered.

CCS is meant to help with recovery. The program works to stabilize and address MH/SUD concerns, which include self-managing physical health and social health and meeting basic needs, such as housing, education, and work. Those enrolled in CCS take control of their treatment and recovery. They work with a team to decide which services and supports will help them reach their goals. These services and supports may include diagnostic tests, help to manage medicines, job-related skills training, peer support, personal and/or family psychoeducation, physical health monitoring, psychotherapy, screening and assessment, skill growth and refinement, SUD treatment, and wellness management and recovery. Services must be psychosocial rehabilitative in nature, and support a person's betterment of health, home, purpose, and community. The services should reflect positive results on quality indicators, participation on recovery teams, adequate supervision, and training to keep the staff skills current and ensure delivery of culturally competent services.

The Wisconsin 2013-2015 biennial budget provided funding to expand CCS statewide. The investment allowed the state to pay the non-federal share of Medicaid costs for counties that adopted a regional service delivery model. This development of regional service models increased access to CCS and created efficiencies in administration. CCS is currently provided to 70 counties and three tribes through certified regions.

Community Support Programs (CSP)
CSP provides coordinated care and treatment through a single agency. This program provides a range of treatment, rehabilitation, and support services in the community through an identified treatment program and staff ensuring ongoing therapeutic involvement and individualized treatment for persons with severe and persistent mental illnesses. Additionally, CSP works collaboratively with other community partners and supports 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 a foundation. Each CSP has multi-disciplinary MH staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, education about mental illness, 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 Wisconsin there are currently 68 certified CSPs providing services to 65 counties. There are three multi-county CSP models: North Central Health Care (Marathon, Lincoln, and Langlade); WRRWC (Chippewa, Pepin, and Buffalo), and Unified Services (Grant and Iowa). Another five of the larger counties have more than one CSP within their county: Brown (2); Dane (4); Milwaukee (7); Rock (2); and Winnebago. Seven counties do not have a certified CSP.

Community Recovery Services (CRS)
Since 2010, Wisconsin has also employed the use of CRS. The program 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.

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 the 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, and to 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. Currently, 17 counties in Wisconsin are actively providing CRS.

Services for Children, Youth, and Young Adults

Coordinated Service Team (CST) Initiatives

CST is designed to develop coordinated systems of care for children and adolescents with Severe Emotional Disorder (SED), and their families who require support from multiple community-based agencies. Under the CST plan a county or tribe is to establish a strength-based system of care that supports children and adolescents along with their families, MH, 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. The 2013-2015 state budget provided funding to expand CST Initiatives statewide. Currently, 67 counties and 10 federally recognized Tribal nations in Wisconsin participate in the CST Initiative. Two counties, Dane, and Milwaukee, provide a managed care model of this service.

Program for Assertive Community Treatment

Another initiative showing very good promise for mitigating disability of youth whose trajectory is into the adult MH system is the youth initiative of the Program for Assertive Community Treatment (PACT). The PACT admits youth before their 18th birthday to help them achieve MH stability and to complete school and obtain employment.

Children's Long-Term Support Waivers

Children's Long-Term Support (CLTS) waivers, managed by the DHS, Division of Medicaid Services address the needs of children aged 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 individuals with intellectual disabilities, 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 community supports available through the waiver are cost-effective and assure that children are at home with their families.

Coordinated Specialty Care (CSC)

The BPTR contracts with Journey Mental Health Center (JMHC), Milwaukee County, and a consortium of 9 counties in Northwest Wisconsin to provide Coordinated Specialty Care Services (CSC) for people experiencing a first episode psychosis. In addition, there are 7 community-based agencies that are undertaking the implementation process to provide CSC in their communities. These agencies are funded by the state using MHBG CAA and ARPA set-aside funds.

The MMHC is a non-profit behavioral health provider organization that began providing CSC services in late 2014 in Dane County. The Milwaukee County Behavioral Health Division, through their Wraparound Milwaukee program, began developing and implementing a CSC model program in 2014-2015. Dunn County Human Services began implementing a regional CSC program in 2020. Programs provide targeted outreach and education about psychosis to education, health, social service, and community agencies that serve youth. Using a wraparound and system of care approach, Wisconsin CSC programs are integrated with other behavioral health and psychosocial rehabilitation programs which facilitate access to providers, supports, and Medicaid funding so that individuals get the help they need when they need it. Programs actively engage with clients and their families by meeting with them in their homes and communities and enlisting the expertise of peer supports. Wisconsin continued funding CSC model programs in FFY 2024 and FFY 2025. New sites were identified through a competitive procurement process in FFY 2025 for upcoming funding years.

Crisis Services

In Wisconsin, Crisis Intervention, administered under DHS 34, subchapter III administrative rule, is available through three modalities, at minimum: 24/7 telephone services; 8 hours per day, 5-days per week walk-in service; and 8-hours per day, 7-days per week mobile services, including mobile crisis outreach. Programs certified under subchapter III are eligible to claim reimbursement for service provision through Wisconsin Medicaid through an established fee-for-service rate structure and private insurers (Wisconsin administrative rule requires Crisis Intervention Services to be covered under Casualty Insurance: INS 3.37). Most of Wisconsin's 72 counties are under an umbrella of DHS 34, subchapter III programs, either as a certified entity themselves or by contracting with a private agency or adjacent county. Starting January 1, 2024, county crisis programs can enroll with Medicaid to receive an enhanced benefit which would allow billing for a team of up to three mobile crisis providers. One requirement to

receive this enhanced benefit is to have mobile crisis teaming available 24 hours a day, 7 days a week. Crisis stabilization services are an optional service certified programs may provide that is covered by Medicaid. In Wisconsin, there are approximately 20 crisis stabilization facilities operated by counties throughout Wisconsin, five regional crisis stabilization facilities that were developed through DHS grant funds, and three youth crisis stabilization facilities supported through DHS grant funds.

Eligibility for subchapter III crisis service is broadly defined as "a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual." Wisconsin Crisis programs are also capable of preparing and implementing a "Crisis Plan" for "an individual at high risk of experiencing a MH crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs." Thus, Crisis programs provide both emergency responses to an emergent situation, as well as anticipatory crisis planning.
Programs are required to provide linkage, coordination, and follow-up services as well. Consequently, these programs are making referrals and connecting individuals and their families to mainstream resources to stabilize a crisis and to prevent the emergence of another. Crisis services have enabled diversion from a great many unnecessary psychiatric hospitalizations. In Wisconsin, for an individual to be involuntarily hospitalized under an emergency detention, the county department of community programs must provide a "crisis assessment" and approve the transfer to a treatment facility. In almost all cases, that authority is with the Crisis Intervention program, delegated to a MH professional under Wisconsin Stats. Chapter 51.15 (2) (c). This requirement affords an opportunity to evaluate the necessity for a hospitalization or alternatively to employ a more trauma- informed, least restrictive alternative such as a community safety plan or a crisis stabilization option, either in-vivo or in a residential setting. Stabilization in place or use of residential stabilization resources are optional services for Subchapter III certified programs. Many counties have residential stabilization facilities for adults, either one to two bed county-licensed Adult Family Homes (AFHs) or larger three to four bed AFHs or five to 16 bed state-licensed Community-Based Residential Facilities (CBRFs). Regionalized crisis stabilization facilities (RCSF) are currently in operation in all five regions of the state, however, based on geography these facilities may not serve all counties within the region. Additionally, there are three operating, certified, youth crisis stabilization facilities in the state which provide short-term, crisis stabilization services for youth.

Suicide and Crisis Lifeline Network
Sixty-five of Wisconsin's 72 counties have Medicaid reimbursable, certified crisis programs which requires them to operate crisis call lines for least 8 hours a day, 7 days a week. County crisis call lines need to be able to provide callers with information, support, counseling, intervention, emergency service coordination, and referrals 24 hours a day, 7 days a week. Wisconsin has one primary 988 Suicide and Crisis Lifeline center that answers all calls, chats, and texts at the 988 Wisconsin Lifeline center and one backup center. Both are operated by Family Services of Northeast Wisconsin. For a couple of years, DCTS partnered with Mental Health America of Wisconsin to develop a new peer support warmline. The warmline was a non-emergency service built for people experiencing MH/SUD concerns and staffed by people who have navigated their own MH/SUDe concerns. In April 2025, this central warmline was discontinued due to a lack of sustainable funding and peer support warmline calls are currently answered by Wisconsin's peer-run respite centers.

All 65 of Wisconsin's DHS 34 certified crisis programs are required to provide linkage, coordination, and follow-up services to persons in crisis as needed and appropriate which may be outlined in their emergency MH services written plan for providing coordinating emergency MH services within the county. The 988 Wisconsin Lifeline assists with referrals for follow-up services to callers, chatters, and texters based on context of the call, need for follow up, and only with the help seekers' consent. A 988 Wisconsin Lifeline data dashboard was developed that tracks referrals made. In its first year of service (July 2022-July 2023), the 988 Wisconsin Lifeline received nearly 92,000 contacts for support. This included about 72,000 calls, about 10,000 texts, and about 9,000 online chats.

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 persons and individuals with physical or developmental disabilities 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 can include some community MH services for some consumers such as outpatient MH and Community Support Program services. However, overall MH services are carved out of the Family Care benefit. 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. Data show that over half of those enrolled in Family Care also carry a MH diagnosis.

Services for Priority Populations
Pregnant Women and Women with Dependent Children
As noted by the Wisconsin Maternal Mortality Review team, women with SUD issues have higher rates of unplanned pregnancies,

and many women do not have the necessary support, treatment, and resources to address their SUD before, during, and after pregnancy. Accessible, gender-responsive SUD treatment services are needed for women, including pregnant women and women with dependent children.

Wisconsin ensures accessible SUD treatment services for pregnant women and women with dependent children through community aids funding to counties. Services are delivered either directly through one of the state's county-administered human service agencies or via sub-contract with a local provider. Counties are required to spend 10 percent or more of their community aids allocation on services for pregnant women and women with dependent children. These programs must offer priority admission to pregnant women and publicize both the availability of services and the prioritization of pregnant women in admission to programming. In addition to community aids funding, additional SUD treatment services for pregnant women and women with dependent children are made available through grant funding distributed to counties, tribes, and local providers under the Women's SU Treatment, Urban/Rural Women's Treatment, and Milwaukee Family-Centered-Treatment Programs. DCTS further increases and enhances the number and quality of SUD disorder prevention, intervention, and treatment services for pregnant women and women with dependent children through training and technical assistance services to counties, community-based providers, and tribes. Training and technical assistance supports providers in developing and implementing evidence-based SUD programming and services for pregnant women and women with dependent children.

Persons at Risk for Tuberculosis (TB)

In 2021, the Wisconsin Tuberculosis Program within DHS reported 66 cases of TB across the state. Wisconsin continues to minimize the number of persons who contract TB through screening and referral efforts, with specific attention to populations who are vulnerable to contracting TB. DHS-funded partners and programs are required to routinely make TB services available, either directly or via referral partnership, to persons receiving treatment for SUD. TB services include screening, counseling and education, testing, evaluation, and treatment. The Division of Quality Assurance (DQA) within DHS monitors behavioral health providers across the state each year to ensure compliance with TB screening and referral requirements. Additionally, counties are required to report on their adherence to TB screening and referral requirements as part of annual reporting.

Services for Special Populations

Rural Populations

Rural areas of Wisconsin mirror national patterns of shortages of MH professionals. This lack of MH professionals, particularly for child and adolescent specialty, has resulted in frequent difficulty finding a psychiatrist for many residents. To increase capacity in rural areas, Wisconsin continues to support several efforts. Key efforts have been the expansion of CCS and CST programs throughout the state. CCS expansion is encouraged to be done in a regional model, allowing counties to pool resources to better serve their residents.

The use of peer specialists is another key initiative Wisconsin is utilizing to increase capacity. Wisconsin has also implemented a dual diagnosis Certified Peer Specialist certification and a Parent Peer Specialist Certification.

The use of Telehealth in Wisconsin since 2007 has been increasing to help address the need for an array of MH/SU services. Because psychiatry services are lacking in many rural areas, recent efforts to increase Telehealth services in Wisconsin include a state-funded Child Psychiatry Consultation Program to provide support to physicians in two programs, one rural and one urban. A child psychiatrist is available via phone to consult with a pediatrician or other primary care physician to support them in providing MH treatment in the primary care office. Telehealth has become increasingly a part of the Wisconsin behavioral health treatment system with the COVID pandemic. Telehealth is covered under Medicaid benefits for most community-based MH/SUDe services, as long as services are functionally equivalent to in-person services.

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 SUD 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 SUD 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 homelessness, mired in the revolving door of high-cost crisis care and emergency housing.

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.

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. The PATH program transitioned from the previous administering agency, the Wisconsin Department of Administration, to the DHS, DCTS at the start of State Fiscal Year (SFY) 18. 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.

Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

DHS is in a period of extensive needs assessment and strategic planning. Priorities are set by the 2023–2027 Wisconsin State Health Improvement Plan and are informed by the 5-year Wisconsin Council on Mental Health Strategic Plan, approved in July 2023. DCTS will implement their strategic plan in Fall 2025; this is the culmination of a four-phase needs assessment and implementation planning process that began in 2023. BPTR has developed a 5-year strategic plan covering 2025-2030. BPTR is also undergoing an extensive behavioral health gaps analysis in partnership with the University of Wisconsin throughout 2025 to identify barriers and needs for the statewide MH/SUD systems through key informant interviews, focus groups, and a partner survey.

The Division of Care and Treatment Services (DCTS) analyzes existing data as part of an ongoing process to inform future policy and funding decisions. A report is developed every other year and data typically highlights the following categories:
· Prevalence of Needs and Service Utilization: The prevalence of disorders, conditions, and associated problems for the entire population is examined. The prevalence in subpopulations is examined when available. The service utilization in the public behavioral health system (county-authorized) is also presented.
· Access to Services: Data on access to services is examined to determine which and how many individuals receive services. Barriers to access are explored.
· Service Workforce and Capacity: Available information on the size of MH/SUD services workforce is examined including the number of providers of these services and the geographic dispersion of the workforce across the state.

Other recent methods of identifying gaps and addressing the needs of priority populations include:
• A six-year Children's System of Care strategic plan was developed in April 2024 with more than 130 partners.
• In January 2024, Governor Evers created the Governor's Task Force on the Healthcare Workforce. The task force issued a report in August 2024 with 10 recommendations and 26 action items.
• In 2024, Governor Evers also created the Interagency Council on Mental Health that brings together 10 state agencies to create a statewide action plan to address Wisconsin's MH crisis.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Wisconsin's behavioral health workforce faces several challenges, including a significant shortage of psychiatrists and other MH professionals. The state sees the most severe deficits in Milwaukee, Outagamie, and Racine counties. Rural areas are particularly affected, though larger counties also face gaps. To address these issues, the DHS Primary Care Program is responsible for tracking health care professional shortages and coordinating funding aimed at mitigating these shortages.

Rural areas of Wisconsin mirror national patterns of shortages of MH professionals. This lack of MH professionals, particularly for the child and adolescent specialty, has resulted in frequent difficulty in finding a psychiatrist. Recent efforts to expand access to providers include an increase in telehealth services in Wisconsin, including a state-funded Child Psychiatry Consultation Program to provide support to physicians in two programs, one rural and one urban. Through this program, a child psychiatrist is available via phone to consult with a pediatrician or other primary care physician to support them in providing MH treatment in the primary care office.

The use of telehealth in MH treatment increased statewide because of the COVID pandemic. UW-Whitewater used MHBG ARPA funding to support qualified treatment trainees and build educational pathways for students seeking careers in behavioral health. Five organizations shared $2.5 million of this funding to recruit and retain psychiatrists trained to serve children through telehealth. Twenty-seven organizations shared $2.5 million of this funding to remove location and technology barriers to care by establishing telehealth stations at community centers, food pantries, homeless shelters, libraries, schools, and similar places.

BPTR encourages counties and community providers to apply for grant funding opportunities (GFO) the bureau issues to address unmet needs and gaps. BPTR designs funding opportunities that are accessible to all groups, including those without professional grant writers.

Resources and tools are provided to assist small organizations in understanding the application process during GFO announcements.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Wisconsin is conducting various training initiatives. One significant effort is the Comprehensive Dialectical Behavioral Therapy (DBT) Training for Teams pilot project, which involves a series of trainings and consultations to prepare clinicians to provide DBT. This project aims to create a statewide roster of trained practitioners who can manage exacerbations of behavioral health needs and suicide crisis behaviors. The Bipartisan Safer Communities Act (BSCA) supplemental funding will expand outreach and training for crisis programs and the state's 988 center to encourage referrals to DBT providers.

Wisconsin aims to enhance service quality and system capacity through the training, certification, employment, and utilization of CPS and CPPS to support those with SMI with(out) co-occurring SUD. The state supports training opportunities for people to become a CPS and CPPS, promotes the benefits of CPS/CPPS involvement in behavioral health care and SUD treatment, and revises curricula to include advocacy as a pillar of peer support. Wisconsin's integrated model for peer specialists includes training and certification for those with lived experience with or supporting those with SUD, MH, or both disorders. The Parent Peer Specialist Training and Certification program uses MHBG funds for curriculum development, certification, and training of CPPS. These specialists use their training and personal experience to guide and support other parents or those in a parenting role.

To improve service outcomes for youth with SED, Wisconsin uses the CST Initiative. DCTS provides ongoing TA, training, and support to state and tribal areas with CST initiatives to improve collaboration, coordination, systems, and outcomes for children and families. Wisconsin aims to improve crisis service quality and facility-based capacity through enhanced training and expanded stabilization services. Efforts include developing new training modules with the UW-Green Bay, promoting enrollment in training modules to enhance crisis workers' skills, and expanding regional efforts for underserved geographical and demographic areas. Counties interested in expanding CCS are encouraged to explore regional models, as they allow counties to pool resources to better serve their residents.

DHS Area Administrators and DCTS representatives attend a joint consultation session with the Tribal State Office and tribal councils twice a year. Quarterly, DHS staff attend the Family Service program directors' meeting with the 11 tribes to learn of local

activities, identify unmet needs, and provide technical assistance, as needed. Monthly, DHS staff members attend meetings with the Tribal State Collaborative for Positive Change that includes MH/SUD coordinators to listen, identify unmet needs, and provide or arrange technical assistance for tribal staff.

DCTS and BPTR are conducting extensive strategic planning. The "Strategic Roadmap Development Approach" began in 2023 and officially kicked off in 2024. DCTS and BPTR planning processes are occurring in parallel and with support provided by the UW Business School. Thirteen work groups have been identifying commonalities among all the individual bureaus' plans. The BPTR 5-year plan will have 17 objectives organized under three pillars (Quality Care, Operational Excellence, Culture and Connections). The State of Wisconsin has a 2-year budget biennium. The governor has proposed numerous priorities concerning MH for the 2025–2027 period, which the legislature will consider in determining the state's budget. The governor's priorities for MH include school MH services, crisis services, peer-run support services, MH workforce, inpatient treatment, residential treatment. Wisconsin plans to expand Medicaid benefits to include a youth psychiatric residential treatment facility benefit and a benefit for adult residential integrated behavioral health stabilization, residential withdrawal management, and residential intoxication monitoring services.

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Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Tuberculosis

Priority Type: SUP, SUT

Population(s): TB

Goal of the priority area:

A minimum of 98 percent of treatment agencies certified by DHS, Division of Quality Assurance (DQA) will be in compliance with TB screening, information, and referral requirements.

Strategies to attain the goal:

In cooperation with the Division of Quality Assurance (DQA) within the Wisconsin Department of Health Services (DHS), identify agencies in non-compliance with TB screening, information, and referral policies and provide follow-up technical assistance to ensure compliance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A minimum of 98 percent of treatment agencies certified by DHS, Division of Quality Assurance (DQA) will be in compliance with TB screening, information, and referral requirements.

Baseline measurement (Initial data collected prior to and during 2026): In CY 2024, DQA Behavioral Health Certification Services conducted 450 re-licensure surveys for Mental Health and Substance Use providers. Of those surveyed, 439 providers (97.5 percent) of providers were in compliance with TB screening/referral requirements

First-year target/outcome measurement (Progress to the end of 2026): In CY 2026, 98 percent of treatment agencies will be in compliance with TB screening/referral requirements.

Second-year target/outcome measurement (Final to the end of 2027): In CY 2027, 98 percent of treatment agencies will be in compliance with TB screening/referral requirements.

Data Source:

Wisconsin Department of Health Services (DHS), Division of Quality Assurance (DQA) and Division of Care and Treatment Services (DCTS).

Description of Data:

(1) Treatment agency citations issued by DQA staff for violations of TB screening, information, and referral policies consisting of a letter to the treatment agency describing the violation. (2) SUPTRS BG Annual Surveys are issued to counties by DCTS. The survey includes a question for counties to confirm they are in compliance with the TB screening, information, and referral requirements under the SUPTRS BG program.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SUP, SUT

Population(s): PWID

Goal of the priority area:

Increase the engagement of persons who inject drugs in county and tribal-authorized services.

Strategies to attain the goal:

(1) Continue strengthening collaborations among DHS, counties, tribes, local service providers, and communities. (2) Monitor the number of treatment admissions of persons who inject drugs with county-authorized providers. (3) Provide training and technical assistance to counties, tribes, service providers, and communities on evidence-based practices and models in injection drug use prevention, outreach, and intervention activities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of persons receiving county-authorized services annually who report injecting drugs.

Baseline measurement (Initial data collected prior to and during 2026): In Calendar Year (CY) 2024, there were 618 persons in county-authorized services who reported injecting as a route of administration for drug use.

First-year target/outcome measurement (Progress to the end of 2026): Assuming no change in national statewide trends of persons who inject drugs, the number of persons receiving county-authorized services who report injecting drugs will increase by at least two percent over the baseline level in CY 2026.

Second-year target/outcome measurement (Final to the end of 2027): Assuming no change in national statewide trends of persons who inject drugs, the number of persons receiving county-authorized services who report injecting drugs will increase by at least two percent over the baseline level in CY 2027.

Data Source:

The Substance Use Disorder (SUD) Module of the Program Participation System (PPS), the State's data submission system for all counties used to collect and submit federal Treatment Episode Data Set (TEDS) data.

Description of Data:

All counties submit data describing all participants served to the PPS SUD Data System. The federal SUPTRS BG requirements as well as State requirements are incorporated into the PPS SUD Data System. The system includes data describing the participant's status at enrollment (such as substance use and route of administration), services received (such as outpatient), and the outcomes of treatment (such as treatment completion, substance use at discharge, support group attendance, and number of arrests at discharge). The specific data her is the count of persons served that year that have needle or injection as the route of administration.

Data issues/caveats that affect outcome measures:

(1) Data quality and completeness issues are minimized through data quality control reports and contracts with reporting agencies. Public substance use services do not fully reflect the scope of substance use services throughout the state. Furthermore, data does not take into account national or state trends, which may reflect yearly fluctuations in the statewide number of persons who inject drugs or the number of persons who inject drugs that are seeking treatment. (2) The indicator's measure covers calendar years because the PPS SUD Module collects county-based treatment data on a calendar year basis.

Priority #: 3

Priority Area: Youth Access to Tobacco Products

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Reduce youth tobacco use.

Strategies to attain the goal:

(1) Continue retailer compliance checks and provide public outreach related to tobacco use prevention, including prevention of vaping, through DHS Division of Public Health's (DPH) Tobacco Prevention and Control Program. (2) Partner with DPH, WI Department of Public Instruction (DPI), and the State Council on Alcohol and Other Drug Abuse (SCAODA) to research and develop policy on reducing the use of vaping, especially among youth.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The proportion of successful purchases of tobacco products by youth will be below 10

percent, using unweighted data rates.

Baseline measurement (Initial data collected prior to and during 2026): In CY 2024, the unweighted Retailer Violation Rate (RVR) was 11.8 percent.

First-year target/outcome measurement (Progress to the end of 2026): The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 12 percent during CY 2026.

Second-year target/outcome measurement (Final to the end of 2027): The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 12 percent during CY 2027.

Data Source:

The Synar compliance check effort is coordinated by the Department of Health Services, Department of Public Health's Tobacco Prevention and Control Program "WI Wins" program. Data will be using an approved sampling scheme.

Description of Data:

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

Data issues/caveats that affect outcome measures:

Note that the indicator's measure covers calendar years because the annual Synar survey data gathering focuses on reviewing and analyzing data which is collected on a calendar year basis.

Priority #: 4

Priority Area: Reduce Adult and Youth Binge Drinking

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Reduce the percentage of adults and youth binge drinking statewide.

Strategies to attain the goal:

(1) Continue working with the Wisconsin Alcohol Policy Project to assist communities in implementing evidence-based environmental prevention and enforcement strategies. (2) Monitor adult and youth binge drinking rates. (3) Work with the Alliance for Wisconsin Youth coalitions to promote implementation of environmental prevention strategies that limit youth access to alcohol. (4) Disseminate information, education, and messaging via the Small Talks campaign.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of adults ages 18-55 who report binge drinking (consuming five or more beverages during an occasion of drinking) with the past 30 days.

Baseline measurement (Initial data collected prior to and during 2026): In CY2023, 30.4 percent of adults in Wisconsin reported binge drinking within the past 30 days.

First-year target/outcome measurement (Progress to the end of 2026): During CY2026, the percentage of adults who report binge drinking in the past 30 days will not exceed 30 percent.

Second-year target/outcome measurement (Final to the end of 2027): During CY2027, the percentage of adults who report binge drinking in the past 30 days will not exceed 30 percent.

Data Source:

National Survey on Drug Use and Health

Description of Data:

The National Survey on Drug Use and Health is a survey of randomly selected individuals who provide state-level estimates on the use of alcohol.

Data issues/caveats that affect outcome measures:

Indicator measure covers calendar years because the annual binge drinking rate data available for adults across Wisconsin is measured by calendar year.

Indicator #: 2

Indicator: The percent of youth ages 12-17 who report binge drinking (consuming five or more beverages during an occasion of drinking) within the past 30 days.

Baseline measurement (Initial data collected prior to and during 2026): In CY2023, 11.3 percent of youth ages 12-17 reported binge drinking within the past 30 days

First-year target/outcome measurement (Progress to the end of 2026): During CY2026, the percent of youth ages 12-17 who report binge drinking will not exceed 11.0 percent.

Second-year target/outcome measurement (Final to the end of 2027): During CY2027, the percent of youth ages 12-17 who report binge drinking will not exceed 11.0 percent.

Data Source:

National Survey on Drug Use and Health: Youth Risk Behavior Survey

Description of Data:

The National Survey on Drug Use and Health is a survey of randomly-selected individuals who provide state-level estimates on the use of alcohol. The Youth Risk Behavior Survey is administered to selected school districts in Wisconsin and provides estimates on youth use of alcohol, including binge drinking.

Data issues/caveats that affect outcome measures:

The indicator measure covered calendar years because the annual binge drinking rate available for youth across is Wisconsin is measured by calendar year.

Priority #: 5

Priority Area: Opioid Misuse

Priority Type: SUT

Population(s): PWWDC, PWID

Goal of the priority area:

Reduce the number of opioid-related deaths in Wisconsin.

Strategies to attain the goal:

(1) Implement best practices for reducing prescription drug availability. (2) Track statistics from the Prescription Drug Monitoring Program (PDMP) and track the number of opioid-related deaths. (3) Provide technical assistance to opioid treatment centers statewide and to providers of opioid treatment services. (4) Continue expanding the availability and use of Naloxone and education on EBPs in opioid use disorder prevention and treatment within communities statewide. (5) Implement best practices for preventing opioid misuse through education and awareness programs offered through several grant programs. (i.e., Prevention Prescription Drug/Opioid Overdose program; State Opioid Response Program).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The annual number of opioid-related overdose deaths.

Baseline measurement (Initial data collected prior to and during 2026): In CY 2024, there were 1,421 opioid-related deaths statewide.

First-year target/outcome measurement (Progress to the end of 2026): During CY 2026, the number of opioid-related deaths statewide will not increase over the CY 2024 baseline of 1,421

Second-year target/outcome measurement (Final to the end of 2027): During CY 2027, the number of opioid-related deaths statewide will not increase over the CY 2024 baseline of 1,421.

Data Source:

WI DHS Vital Records Death Data, Office of Health Informatics.

Description of Data:

Death certificate records are counted by the Office of Health Information with the Division of Public Health, DHS.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: The number of persons with an opioid-related substance problem who received county-authorized services.

Baseline measurement (Initial data collected prior to and during 2026): During CY 2024, 2,331 persons with an opioid-related substance use issue recieved county-authorized services.

First-year target/outcome measurement (Progress to the end of 2026): During CY 2026, the number of persons receiving county-authorized services with an opioid -related substance use issue will increase by 5 percent over the 2024 baseline level.

Second-year target/outcome measurement (Final to the end of 2027): During CY 2027, the number of persons receiving county-authorized services with an opioid -related substance use issue will increase by 5 percent over the 2024 baseline level.

Data Source:

The Substance Use Disorder (SUD) Module of the Program Participation System (PPS), the State's data submission system for all counties is used to collect and submit federal Treatment Episode Data Set (TEDS) data.

Description of Data:

All counties submit data describing all participants served to the PPS SUD Data System. The federal SUPTRS BG requirements as well as State requirements are incorporated into the PPS SUD Data System. The system includes data describing the consumer's status at enrollment (such as substance misuse and route of administration), services received (such as outpatient), and the outcomes of treatment (such as treatment completion, substance use at discharge, support group attendance, and number of arrests at discharge). The specific data here is the count of persons served that year that reported opioid as their primary, secondary, or tertiary substance use.

Data issues/caveats that affect outcome measures:

Data quality and completeness issues are minimized through data quality control reports and contracts with reporting agencies. Public substance use services do not fully reflect the scope of substance use services throughout the state. Indicator measures covers calendar years because the PPS SUD Module collects county-based treatment data on a calendar year basis.

Priority #: 6

Priority Area: Stimulant Use Disorder

Priority Type: SUP, SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Expand intervention and treatment for stimulant use disorder.

Strategies to attain the goal:

(1) Provide training and technical assistance on evidence-based stimulant misuse treatment and prevention practices to counties, tribes, and coalitions across the state. (2) Continue monitoring the number of persons receiving stimulant use treatment statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of persons with a methamphetamine-related substance use issue who received county-authorized services annually.

Baseline measurement (Initial data collected prior to and during 2026):	During CY 2024, 2,001 persons with a methamphetamine-related substance use issue received county-authorized services.
First-year target/outcome measurement (Progress to the end of 2026):	During CY 2026, the number of persons with a methamphetamine-related substance use issue receiving county-authorized services will increase by at least five percent over the baseline level.
Second-year target/outcome measurement (Final to the end of 2027):	During CY 2027, the number of persons with a methamphetamine-related substance use issue receiving county-authorized services will increase by at least five percent over the first year level.

Data Source:

The Substance Use Disorder (SUD) Module of the Program Participation System (PPS), the State's data submission system for all counties used to collect and submit federal Treatment Episode Data Set (TEDS) data.

Description of Data:

All counties submit data describing all participants served to the PPS SUD Data System. The federal SUPTRS BG requirements as well as State requirements are incorporated into the PPS SUD Data System. The system includes data describing the consumer's status at enrollment (such as substance misuse and route of administration), services received (such as outpatient), and the outcomes of treatment (such as treatment completion, substance use at discharge, support group attendance, and number of arrests at discharge). The specific data here is the count of persons served that year that reported opioid as their primary, secondary, or tertiary substance use.

Data issues/caveats that affect outcome measures:

Data quality and completeness issues are minimized through data quality control reports and contracts with reporting agencies. Public substance use services do not fully reflect the scope of substance use services throughout the state. Indicator measures covers calendar years because the PPS SUD Module collects county-based treatment data on a calendar year basis.

Priority #: 7

Priority Area: Behavioral Health Services in the Criminal Justice System

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Improve the quality and effectiveness of behavioral health services in the criminal and juvenile justice systems.

Strategies to attain the goal:

(1) Provide technical assistance to providers on implementing evidence-based practices to address the behavioral health needs of people in the criminal and juvenile justice systems. (2) Expand the number of persons at risk of incarceration that receive SUD treatment and interventions in Treatment Alternative Programs (TAPs).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of people who participated in a Treatment Alternative Program (TAP).
Baseline measurement (Initial data collected prior to and during 2026):	During CY 2022, 70 persons participated in a TAP.
First-year target/outcome measurement (Progress to the end of 2026):	During CY 2026, the number of persons participating in a TAP will increase five percent over the baseline measure.
Second-year target/outcome measurement (Final to the end of 2027):	During CY 2027, the number of persons participating in a TAP will increase five percent over the first year measure.

Data Source:

TAO contract records, training forms and records; County and/or Tribal agency client records; DHS/DCTS staff records.

Description of Data:

TAP program administrative and client records.

Data issues/caveats that affect outcome measures:

(1) In the past, we have experienced some inaccuracies and uncertainties with the data reported by the TAPs. DCTS staff continues to work to refine our reporting requests and data collection methods to improve the level of accuracy. (2) Indicator measure covers calendar years because the TAP contracts are set up as calendar year programs.

Priority #: 8

Priority Area: Early Intervention for First Episode Psychosis

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Prevent long-term disability and severity of psychotic disorders through early intervention utilizing the Coordinated Specialty Care (CSC) model.

Strategies to attain the goal:

1. Continue providing funding for established CSC programs. 2. Provide technical assistance, training, fidelity monitoring, program monitoring, and oversight to Wisconsin's CSC programs. 3. Provide ongoing CSC program evaluation and outcome monitoring. 4. Continue to develop Wisconsin's system capacity for future CSC program expansion and continue to develop means of program sustainability. 5. Implement additional CSC model programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of youth and young adults receiving CSC model services.

Baseline measurement (Initial data collected prior to and during 2026): In FY 2024, 197 youth and young adults received CSC model services.

First-year target/outcome measurement (Progress to the end of 2026): In FY2026, an additional 15 youth and young adults will receive CSC model services above the baseline number served.

Second-year target/outcome measurement (Final to the end of 2027): In FY2027, an additional 15 youth and young adults will receive CSC model services above the first-year target number served.

Data Source:

Annual program reports from Wisconsin's MHBG funded CSC programs.

Description of Data:

Service provision reports provided to the Wisconsin Department of Health Services by contracted CSC providers.

Data issues/caveats that affect outcome measures:

Priority #: 9

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Prevent suicide and suicide attempts in Wisconsin.

Strategies to attain the goal:

1. Support and expand systems change approaches in health care settings serving individuals with SMI/SED to strengthen suicide prevention policies,

procedures, and practices in those settings. 2. Support development of the mental health workforce through training in recognizing, assessing, managing, and responding to suicide risk in populations with SMI/SED.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of behavioral health organizations, including county-based systems, that have completed the Wisconsin Zero Suicide Training.

Baseline measurement (Initial data collected prior to and during 2026): Four behavioral health organizations completed the Wisconsin Zero Suicide Training in Federal Fiscal Year 2025.

First-year target/outcome measurement (Progress to the end of 2026): Four behavioral health organizations completed the Wisconsin Zero Suicide Training in Federal Fiscal Year 2026.

Second-year target/outcome measurement (Final to the end of 2027): Four behavioral health organizations completed the Wisconsin Zero Suicide Training in Federal Fiscal Year 2027.

Data Source:

Division of Care and Treatment Services administrative records and contract performance reports.

Description of Data:

Number of behavioral health organizations completing training in the Zero Suicide Model as reported by the contractor.

Data issues/caveats that affect outcome measures:

Priority #: 10

Priority Area: Children's Mental Health

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Improve service outcomes for youth with SED through the use of Coordinated Services Teams (CST) Initiatives.

Strategies to attain the goal:

1.Provide on-going technical assistance, training, and support to areas of the state/tribes with CST Initiatives to improve collaboration, coordination, system improvements, and outcomes for children and families. 2. Providing training and Technical Assistance on development of local systems of care. 3. Review data on child and family outcomes of CST Initiatives and identify quality improvement objectives. 4. Provide training on the use of Evidence Based Practices (EBP) and training for sites to self-monitor their fidelity.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of youth who have completed CST services with “major or moderate” improvement as reported by the CST provider.

Baseline measurement (Initial data collected prior to and during 2026): 43% of CST youth participants will complete their services with “major or moderate” improvement at discharge (2024).

First-year target/outcome measurement (Progress to the end of 2026): 44% of CST youth participants will complete their services with “major or moderate” improvement at discharge (2026).

Second-year target/outcome measurement (Final to the end of 2027): 45% of CST youth participants will complete their services with “major or moderate” improvement at discharge (2027).

Data Source:

The Mental Health Module of the Program Participation System (PPS) – the State’s data submission system for all counties.

Description of Data:

All counties submit data describing all consumers served to the PPS MH data system. The federal MHBG requirements as well as State requirements are incorporated into the PPS MH data system. The system includes data describing the consumer's needs at enrollment (such as diagnosis), services received (such as outpatient vs. inpatient), and the outcomes of treatment (such as clinical improvement and functioning) which are reported every 6 months as long as a consumer is receiving services.

Data issues/caveats that affect outcome measures:

Priority #: 11

Priority Area: Crisis Services

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Improve crisis service quality and facility-based capacity through enhanced training and expanded stabilization services.

Strategies to attain the goal:

Identify new and enhanced training modules with contractor University of Wisconsin-Green Bay. Promote enrollment in training modules to increase the skill set of crisis workers in the behavioral health system and promote a team based mobile crisis approach.

Identify current number of Wisconsin counties who have access to youth crisis stabilization facilities and adult regional crisis stabilization facilities. Promote the use of adult and youth stabilization facilities. Expand regionalization efforts to underserved geographical and demographic areas in Wisconsin.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of crisis workers trained in Mobile Crisis Teaming in Wisconsin.

Baseline measurement (Initial data collected prior to and during 2026): As of August 2025, there are 250 people registered to become trained in mobile crisis team training.

First-year target/outcome measurement (Progress to the end of 2026): As of October 2026, an additional 50 people, above baseline, will have been trained in at least one new training module.

Second-year target/outcome measurement (Final to the end of 2027): As of October 2027, an additional 30 people, above first-year target, will have been trained in at least one new training module.

Data Source:

Contract data provided by University of Wisconsin Behavioral Health Training partnership.

Description of Data:

Count of registered persons completing training.

Data issues/caveats that affect outcome measures:

Priority #: 12

Priority Area: Certified Peer Specialists

Priority Type: SUT, MHS

Population(s): SMI, SED

Goal of the priority area:

Increase service quality and system capacity through the training, certification, employment, and utilization of Certified Peer Specialists (CPS), and Certified Parent Peer Specialists (CPPS).

Strategies to attain the goal:

1. Provide and support training opportunities for people to become CPS and CPPS. 2. Promote the benefits of CPS/CPPS involvement in behavioral health care and substance use disorder treatment settings to increase utilization of CPS/CPPS in the behavioral health system. 3. The curriculum for both peer and parent peer was revised in 2022 to include advocacy as a pillar of peer support and to integrate language, examples, and content that is more culturally competent or relevant throughout the curriculums versus in one section.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Certified Peer Specialists in Wisconsin.

Baseline measurement (Initial data collected prior to and during 2026): As of August 2024, there were 1368 Certified Peer Specialists in Wisconsin.

First-year target/outcome measurement (Progress to the end of 2026): As of Sept. 2026, an additional 40 people, above baseline, will have become Certified Peer Specialists.

Second-year target/outcome measurement (Final to the end of 2027): As of Sept. 2027, an additional 40 people, above the first-year target, will have become Certified Peer Specialists.

Data Source:

Contract data provided by Certified Peer Specialist examination provider.

Description of Data:

Count of new people successfully achieving Certified Peer Specialist Certification.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of Certified Parent Peer Specialists in Wisconsin

Baseline measurement (Initial data collected prior to and during 2026): As of August 2025, there were 54 Certified Parent Peer Specialists in Wisconsin.

First-year target/outcome measurement (Progress to the end of 2026): As of Sept. 2026, an additional 10 people, above baseline, will have become Certified Parent Peer Specialists.

Second-year target/outcome measurement (Final to the end of 2027): As of Sept. 2027, an additional 10 people, above the first-year target, will have become Certified Parent Peer Specialists.

Data Source:

Contract data provided by Certified Peer Specialist examination provider.

Description of Data:

Count of new people successfully achieving Certified Parent Peer Specialist Certification.

Data issues/caveats that affect outcome measures:

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$20,341,836.00		$297,738.00	$30,208,558.00	$14,001,266.00	$21,890,702.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$5,041,861.00				$619,522.00	$619,522.00		
b. All Other	$15,299,975.00		$297,738.00	$30,208,558.00	$13,381,744.00	$21,271,180.00		
2. Recovery Support Services[c]	$250,024.00							
3. Primary Prevention[d]	$7,075,627.00			$1,624,976.00	$966,224.00	$3,978,730.00		
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]								
13. Administration[g]	$182,716.00							
14. Total	**$48,192,039.00**		**$595,476.00**	**$62,042,092.00**	**$28,968,756.00**	**$47,760,134.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$3,200,000.00						$227,016.00
7. State Hospital			$35,800,000.00		$229,600,000.00	$107,000,000.00		
8. Other Psychiatric Inpatient Care			$128,800,000.00		$7,000,000.00			
9. Other 24-Hour Care (Residential Care)					$60,800,000.00	$212,600,000.00		$300,000.00
10. Ambulatory/Community Non-24 Hour Care		$22,185,084.00	$1,352,000,000.00	$860,000.00				
11. Crisis Services (5 percent Set-Aside)[c]		$4,000,000.00		$3,788,000.00				$1,743,144.00
12. Other Capacity Building/Systems Development								
13. Administration		$480,000.00						
14. Total		**$29,865,084.00**	**$1,516,600,000.00**	**$4,648,000.00**	**$297,400,000.00**	**$319,600,000.00**	**$0.00**	**$2,270,160.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	5553	100
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	422000	0
Persons who inject drugs	0	2389
Persons experiencing homelessness	0	1135

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

*Wisconsin Treatment data sets do not currently collect data from missing cells. 1. Pregnant Women: 5,553 is representative of 9.3 percent of 59,719 Wisconsin live births 2. Women with Dependent Children: data unavailable 3. Individuals with co-occurring M/SUD: 422,000 is representative of 9.2 percent of Wisconsin's 18yo+ population. In treatment data unavailable 4. Persons who inject drugs: estimated treatment data unavailable 5. Persons experiencing homelessness: estimated treatment data unavailable

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Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$20,341,836.00
2 . Recovery Support Services[b]	$250,024.00
3 . Substance Use Primary Prevention[c]	$7,075,627.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$0.00
7 . Administration[f]	$182,716.00
8. Total	$27,850,203.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	565873.00
1b. Crisis Services for Adults	2000000.00
1c. CSC/ESMI program for Adults	1600000.00
1d. Other outpatient/ambulatory services for Adults	
1e. *Other Direct Services for Adults	3670400.00
2. Subtotal of Services for Adults	7836273.00
3. Services for Children	
3a. EBPs for Children	141160.00
3b. Crisis Services for Children	500000.00
3c. CSC/ESMI program for Children	
3d. Other outpatient/ambulatory services for Children	
3e. *Other Direct Services for Children	1957000.00
4. Subtotal of Services for Children	2598160.00
5. Other Capacity Building/Systems Development[a]	4258109.00
6. Administrative Costs[b]	240000.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**14932542.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$414,518
	Selective	$6,486
	Indicated	$6,727
	Unspecified	
	Total	**$427,731**
2. Education	Universal	$3,559,260
	Selective	$481,345
	Indicated	$728,245
	Unspecified	
	Total	**$4,768,850**
3. Alternatives	Universal	$476,086
	Selective	$22,961
	Indicated	
	Unspecified	
	Total	**$499,047**
4. Problem Identification and Referral	Universal	$10,867
	Selective	
	Indicated	$3,580
	Unspecified	
	Total	**$14,447**
	Universal	
	Selective	$28,154

5. Community-Based Processes	Indicated	$111,724
	Unspecified	
	Total	**$139,878**
6. Environmental	Universal	$846,464
	Selective	$1,057
	Indicated	
	Unspecified	
	Total	**$847,521**
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$6,697,474**
Total Award [a]		**$27,850,203**
Planned Primary Prevention Percentage		**24.05%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$3,342,310
2. Universal Indirect	$2,228,207
3. Selective	$573,128
4. Indicated	$654,478
5. Column Total	**$6,798,123**
6. Total SUPTRS Award[a]	**$27,850,203**
7. Primary Prevention Percentage	**24.41%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☐
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☐
Military Families	☐
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

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Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$16,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$16,000.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$100,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$100,000.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$50,000.00	$0.00	$100,000.00

a. Single State Agency (SSA)	$50,000.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$100,000.00
7. Training and Education	$50,000.00	$0.00	$61,504.00
a. Single State Agency (SSA)	$50,000.00	$0.00	$61,504.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$100,000.00**	**$0.00**	**$277,504.00**

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Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 01/01/2026 MHBG Planning Period End Date: 01/01/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support	$2,336,076.00	$150,000.00
3. Partnerships, Community Outreach, and Needs Assessment	$325,000.00	
4. Planning Council Activities	$20,000.00	
5. Quality Assurance and Improvement	$486,450.00	
6. Research and Evaluation	$188,000.00	
7. Training and Education	$902,583.00	
8. Total	**$4,258,109.00**	**$150,000.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

The Wisconsin Department of Health Services (DHS) strives for increased access to care for MH, SUD, and co-occurring treatment. Additional support has been provided through the development of peer services such as peer run respites, peer recovery centers, and peer run warmline services focused on supporting consumers with MH/SUD needs. Many adults with SMI and children and youth with SED are served through CCS, which provides an array of psychosocial rehabilitation supports and services across the state. A more intensive multidisciplinary team approach is provided through CSP for adults and transition-aged youth. BPTR provides training and technical assistance to CCS and CSP providers to ensure quality care is available and accessible. Funding supports women's SUD residential treatment with a focus on ensuring this population has first priority for services. Additionally, family-centered services for SUD have been expanded. Overdose prevention efforts have expanded greatly throughout Wisconsin in an attempt to address the opioid epidemic with additional supports for the distribution of naloxone, expansion of public health vending machines, mobile medication units, and lower-level buprenorphine induction. BPTR funds services for youth involved in the justice system through CST and youth diversion services, continually analyzing how to increase access for this population and collaborate with partners to strengthen services. In 2024, Wisconsin held a Children's System of Care Summit focused on the development of an action plan to expand access to treatment for youth with serious emotional disturbances and/or SUDs. Evidence-based treatment has been emphasized in all populations. Wisconsin supported the implementation of 988 in an effort to expand access to crisis care and services and has focused funding on the support and further development of Qualified Treatment Trainees (QTTs) to build the clinical workforce throughout the state.

DHS is actively working to understand and address the issue of suicide in the state; having observed a significant increase in suicide attempts since 2017. DHS engaged a marketing firm to conduct focus groups with high-risk populations, such as first responders and veterans, to better understand their needs and identify effective support strategies. Counties experiencing student deaths by suicide on college campuses are reaching out to DHS for support. The state has invested in Crisis Intervention Team training for law enforcement officers; when funding permits, this training is extended to first responders. This initiative is carried out in partnership with the National Alliance on Mental Illness (NAMI) Wisconsin.

Wisconsin prioritized the development of regional crisis stabilization facilities (RCSFs) to increase access to care in the five regions of Wisconsin. Because counties are responsible for treating individuals experiencing crisis, it is imperative that facilities and experts be available within an appropriate distance and timeframe to provide care. RCSF facilities are equipped to handle any level of crisis stabilization and collaborate with helplines, including 988, hospitals, residential facilities, and community providers. These facilities aim to increase access to care, decrease reliance on emergency departments and psychiatric hospitalizations, reduce jail time, and keep individuals in their communities. Five RCSFs were established to provide a regionalized approach to crisis stabilization, giving more people access to these services. Funding remains a challenge for RCSFs; a portion of one of the five facilities in La Crosse County closed due to funding uncertainty.
Expansion of the crisis system in Wisconsin includes crisis care facilities (CCFs) and crisis hostels. A CCF intends to be a multi-pronged facility, including a 24/7 walk-in component, an observation area where individuals can be observed for less than 24 hours, the ability to take involuntary individuals detained on emergency detention, and the capacity to convert involuntary care to voluntary care within the facility. Administrative rule writing began in the summer of 2024 and the final rule will be published in early 2026. In the most recent biennium, state funding is provided to support the development of one to two new CCF sites. A GFO will be issued to identify the facilities, which could be standalone or attached to a hospital system. Medicaid funding will also be available for CCF consumers who have coverage.

There is a concurrent rule-writing project for crisis hostels, which are services under the DHS 34 administrative code for crisis services. These hostels are intended for voluntary stabilization for individuals who need care for 23 or fewer hours; they provide short-term, facility-based crisis care. One crisis hostel currently exists in Racine County, which prompted the inclusion of crisis hostels in the legislative act.
The Behavioral Health Training Partnership, run by the UW Green Bay, developed crisis services training, including a crisis core training that meets all administrative requirements in statute. Counties can partner and access crisis core training, CCS track, and other ad hoc training about MH treatment and supervision. Approximately 40–50 counties are part of the partnership, which offers training at a lower cost. Partnerships with other agencies and workgroups have helped develop crisis-focused training for providers who work with individuals with I/DD, youth, incarcerated individuals, and patients with dementia.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Wisconsin continues to consider parity in partnership with the Division of Medicaid Services (DMS) and the Office of the Commissioner of Insurance. BPTR has work groups that focus on different populations to ensure equitable funding access to all individuals in Wisconsin. BPTR designs funding opportunities that are accessible to all groups, including those without professional grant writers and provides resources and tools to assist small organizations in understanding the application process during the GFO periods.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and**

substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

a. Please describe how this system differs for youth and adults.

Wisconsin has a separate children's section which focuses on the integration of MH/SUD for that population and a Children Come First Advisory Committee which focuses on integration and improvement of services. Wisconsin is creating a seamless children's behavioral health system and has focused on the development of a systems of care framework, including establishing best practices for working with children and families in the CST and CCS programs.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Comprehensive Community Services (CCS), the state's psychosocial rehabilitation program, is funded by state GPR and Medicaid dollars and is an integrated MH/SUD program provided by counties for individuals with complex needs. CCS providers offer evidence-based integrated treatment for co-occurring disorders through various therapeutic modalities. The QTT support program is focused on training and education for clinical supervisors and QTTs in relation to integrated treatment. There is certification through DHS 75 that allows for the certification of integrated behavioral health clinics for co-occurring outpatient clinics and treatment expansion. This is similar for both the adult and youth systems. Care coordination is provided through numerous Medicaid program benefits and grant funding allocated to providers throughout the state. It is a required component of all psychosocial rehabilitation programs, including CCS, Community Support Programs (CSP), Coordinated Services Teams (CST), and programs funded by Medicaid and provided by county human service agencies. Funding provided to Tribal nations, counties, and treatment providers also supports care coordination as a beneficial and supportive model for individuals with complex needs.

Service coordination is central to Wisconsin's CST initiatives, a core strategy for improving service outcomes for Wisconsin youth with SED. DHS supports CST initiatives by providing ongoing technical assistance, training, and support to areas of the state and Tribal nations with CST initiatives. Training and technical assistance is provided to support the use of evidence-based practices (EBP) and identify methods to self-monitor fidelity data on child and family outcomes in CST initiatives.

c. How many IT-COD teams do you have? Please explain.

BPTR has five sections which promote fully integrated MH/SUD services and systems in order to provide evidence-based treatment for co-occurring disorders.

d. Do you monitor fidelity for IT-COD? Please explain.

A system of care self-assessment tool has been developed for Tribal nations and counties to assess progress on the development of their local system of care. The results of the assessment can be used to develop a local plan to improve specific areas of need and by DHS to make data-driven decisions in the provision and development of technical assistance.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

Through the State Opioid Response grant and partnership with federally qualified health centers (FQHCs), Wisconsin continues to integrate behavioral health and primary health care for individuals with MH, SUD, and co-occurring disorders. Wisconsin has supported the implementation of the state psychosocial rehabilitation benefit, CCS, as well as increased access to crisis interventions by supporting partnerships with county behavioral health systems and FQHCs. There has also been an emphasis on expanding the use of medication for opioid use disorders through education to primary care providers and support of low-level buprenorphine induction in multiple clinics. Peer and recovery supports have been embedded into hospital emergency departments (EDs) to form connections to individuals with opioid use disorders seen in EDs. Wisconsin is also piloting a SUD health home model focused on twelve core components of care in a hub and spoke model. This is a Medicaid-funded pilot to expand access, integrated care, and better practice for the complexities of this population.

Wisconsin aims to enhance service quality and system capacity through the training, certification, employment, and utilization of Certified Peer Specialists (CPS) and Certified Parent Peer Specialists (CPPS). The state supports training opportunities for people to become a CPS and CPPS, promotes the benefits of CPS/CPPS involvement in behavioral health care and SUD treatment, and revises curricula to include advocacy as a pillar of peer support. Wisconsin's integrated model for peer specialists includes training and certification for those with lived experience with or supporting those with SUD, MH, or both disorders. The Parent Peer Specialist Training and Certification program uses MHBG funds for curriculum development, certification, and training of CPPS. These

specialists use their training and personal experience to guide and support other parents or those in a parenting role.

To improve service outcomes for youth with SED and cooccurring disorders, Wisconsin uses the CST Initiative. DCTS provides ongoing technical assistance, training, and support to subgrantees with CST initiatives to improve collaboration, coordination, systems, and outcomes for children and families. Wisconsin aims to improve crisis service quality and facility-based capacity for individuals with MH and SUD through enhanced training and expanded stabilization services. Efforts include developing new training modules with the UW-Green Bay, promoting enrollment in training modules to enhance crisis workers' skills, and expanding regional efforts for underserved geographical and demographic areas. Counties interested in expanding CCS, which utilizes integrated care, are encouraged to share resources and develop regional models to better serve their residents. Wisconsin Intellectual and Developmental Disabilities and Mental Health (I/DD-MH) System Improvement aims to improve systems and services for people who have I/DD-MH needs. The project started in 2022 when the National Center for START Services evaluated the state's service system for people with I/DD-MH needs. The evaluation resulted in the START Scan. The project steering committee released the Wisconsin I/DD-MH System Improvement Report in June 2024. This report is the work of more than 1,300 self-advocates, providers, and partners who collaborated to provide these recommendations through the project steering committee, subcommittees, and work group. The report gives 37 specific recommendations for improving systems and services for people with I/DD-MH needs in Wisconsin.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Care coordination is provided through numerous Medicaid program benefits as well as grant funding allocated to providers throughout Wisconsin. It is a required component of all psychosocial rehabilitation programs including CCS and CSP, programs funded by Medicaid and provided by county human service agencies, as well as CST and the wraparound model of care for children and youth, supported though contractual agreements with Tribal nations and counties. Funding provided to Tribal nations, counties, and treatment providers is also able to support care coordination as a beneficial and supportive model for individuals with complex needs. Care coordination is a key element of the pilot SUD health home model in Wisconsin.

CCS is an integrated MH/SUD fee for service Medicaid program provided by counties for individuals with complex needs that outpatient services are not able to meet. To expand integrated services for youth with SED/SUD, Wisconsin allows licensed MH clinicians and those in training to provide SUD treatment in CCS. There are initiatives in the state, such as the QTT support program, focused on training and education for supervisors and QTTs in relation to care coordination in integrated treatment. There is certification through DHS 75 that allows for the certification of youth and adult SUD services, and care coordination is built into this administrative code and Medicaid reimbursement to ensure persons are in the right level of care and coordination occurs between providers.

Care coordination is central to Wisconsin's CST initiatives, which form a core strategy for improving service outcomes for Wisconsin youth with SED. DHS supports CST initiatives by providing ongoing technical assistance, training, and support to areas of the state and tribes with CST initiatives; providing training and technical assistance on the development of local systems of care; reviewing data on child and family outcomes in CST initiatives and identifying quality improvement objects; and providing sites with training on the use of EBPs and ways to self-monitor their fidelity.

Wisconsin has been working toward creating a more seamless children's behavioral health system and has focused on developing Wisconsin's systems of care framework, including establishing best practices for working with children and families in the CST and CCS programs and creating a system-of-care self-assessment tool that Tribal nations and counties can use to assess where they are at in the development of their local system of care. The results of the assessment can be used locally to develop a plan to improve specific areas of need through enhanced care coordination.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Wisconsin has a separate children's section which focuses on the integration of MH/SUD for that population and a Children Come First Advisory Committee which focuses on integration and improvement of services. Wisconsin is creating a seamless children's behavioral health system and has focused on the development of a systems of care framework, including establishing best practices for working with children and families in the CST and CCS programs.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment

that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

To improve service outcomes for youth with SED and cooccurring disorders, Wisconsin uses the CST Initiative. DCTS provides ongoing technical assistance, training, and support to subgrantees with CST initiatives to improve collaboration, coordination, systems, and outcomes for children and families. Wisconsin aims to improve crisis service quality and facility-based capacity for individuals with MH and SUD through enhanced training and expanded stabilization services. Efforts include developing new training modules with the UW-Green Bay, promoting enrollment in training modules to enhance crisis workers' skills, and expanding regional efforts for underserved geographical and demographic areas. Counties interested in expanding CCS, which utilizes integrated care, are encouraged to share resources and develop regional models to better serve their residents. Wisconsin Intellectual and Developmental Disabilities and Mental Health (IDD-MH) System Improvement aims to improve systems and services for people who have IDD-MH needs. The project started in 2022 when the National Center for START Services evaluated the state's service system for people with IDD-MH needs. The evaluation resulted in the START Scan. The project steering committee released the Wisconsin IDD-MH System Improvement Report in June 2024. This report is the work of more than 1,300 self-advocates, providers, and partners who collaborated to provide these recommendations through the project steering committee, subcommittees, and work group. The report gives 37 specific recommendations for improving systems and services for people with IDD-MH needs in Wisconsin.

8. Please indicate areas of **technical assistance needs** related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC)	3.00
	0.00
	0.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,600,000.00	1,600,000.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Wisconsin Coordinated Specialty Care (CSC) programs receive ongoing technical assistance and support to provide CSC services within existing systems of care including community-based psychosocial rehabilitation programs which are part of the county- and tribal-based public MH systems. Most of the components of CSC are Medicaid eligible under these programs. Two of the three programs have established billing practices via these programs. One of the programs is navigating the challenges of a multi-county Medicaid system and working to improve the billing practices. Two of the programs have worked with private insurances to develop case rates and/or fee-for-service billing for participants who are not eligible for Medicaid programs.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The Wisconsin Bureau of Prevention Treatment and Recovery (BPTR) contracts with Journey Mental Health Center, Milwaukee County, and a consortium of 9 counties in north-west Wisconsin to provide Coordinated Specialty Care Services (CSC) for people experiencing a first episode psychosis. These programs are funded by the MHBG via the 10% set-aside. In addition, there are 7 community-based agencies that are undertaking the implementation process to provide CSC in their communities. These agencies are funded by the state using CAA and ARPA set-aside funds.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

CSC programs in Wisconsin provide targeted outreach and education about psychosis to education, health, social service, and community agencies that serve youth. Using a wraparound and system of care approach, Wisconsin CSC programs are integrated with other behavioral health and psychosocial rehabilitation programs which facilitate access to providers, supports, and Medicaid funding so that individuals get the help they need when they need it. Programs actively engage with clients and their families by meeting with them in their homes and communities and enlisting the expertise of peer supports.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Wisconsin plans to continue funding CSC model programs in FFY 2026 and FFY 2027. It is anticipated that all current providers will continue to receive funding in FFY 2026, and new sites will be identified through a competitive procurement process in FFY 2027.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

The estimated incidence rate of individuals who experience FEP each year in Wisconsin is approximately 3,480 from the general population, 663 young adults ages 15-24, and about 4,300 Medicaid recipients. This is based on a population of 6 million (Wisconsin Department of Administration, 2022), about 771,000 young adults ages 15-24 (Office of Health Informatics, 2020), and Medicaid enrollment of approximately 1.6 million (Forward Health, 2022). The incidents rates used are as follows: median annual incidence rate of 58 per 100,000, young adult incidence rate of 86 per 100,000 (Simon, et al., 2017) and Medicaid population incidence rate of 272 per 100,000 (Radigan, et al., 2019).

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Wisconsin CSC programs receive ongoing technical assistance and support to provide CSC services within existing systems of care including community-based psychosocial rehabilitation programs which are part of the county- and tribal-based public MH systems.

12. Please indicate area of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Wisconsin has a deep commitment to supporting the implementation of recovery-oriented, person-centered practice. Wisconsin has three certified psychosocial rehabilitation programs. All require staff to utilize Person-Centered Planning (PCP) when engaging consumers and their natural supports in services and planning. Each program requires staff to receive training to learn the skills for effectively partnering with each person in every aspect of services, explicitly around goal setting and decision-making. The inclusion of every consumer's voice is visible as evidenced by person-centered program documentation, including new client and annual assessments, individualized recovery and treatment plans, and provider notes. The Wisconsin Department of Health Services (DHS) provides regular training opportunities on how to effectively engage and utilize family and natural supports during the entire planning process, including service provision.

The statewide psychosocial rehabilitation programs are inclusive of person-centered philosophies and use of PCP. For example, DHS 36.16 (d) Comprehensive Community Services (CCS), outlines that the CCS assessment process "shall incorporate the consumer's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, resources and needs in each of the domains included in the assessment process." Furthermore, CCS is structured to have local coordinating committees oversee the quality improvement process and members of that committee must be one third consumers or family members.

Community Support Programs (CSP) in Wisconsin are required to share completed assessments with the person and the person's guardian and family (DHS 63.10 (b)).

Community Recovery Services (CRS) in Wisconsin ensure their assessment process incorporates "the consumer's unique perspective and own words about how they view their recovery, experience, challenges, strengths, resources and needs in each of the assessment domains. Cultural and environmental supports should be identified and incorporated as they affect identified goals and desired outcomes and preferred methods for achieving the identified goals." Furthermore, recent guidance outlines that CRS program staff and contracted providers must receive training in person-centered care and planning.

All programs are required to conduct an annual satisfaction survey of consumers, including parents of consumers if the consumer is a minor, and utilize those findings to make improvements.

4. Describe the person-centered planning process in your state.

As stated above, Wisconsin's three psychosocial rehabilitation programs invite involvement from consumers and families, especially in the assessment, goalsetting, and planning processes. Each program requires providers to receive PCP training. The BPTR has one contracted staff to provide PCP training and technical assistance to providers who request it. Training and technical

assistance about PCP is available to all Wisconsin DHS partners, including programs that do not require PCP. Wisconsin DHS outlines a model for PCP that includes practice measures of fidelity and guidance for the implementation of this model. In 2020, Wisconsin launched a virtual PCP training that is self-paced, available at no cost, and is on-demand to the public. This ensures MH/SUD provider has access to timely, clear, and effective training on critical PCP elements. Agencies utilize this training for new hires and as an annual training for providers. Additional training and technical assistance is provided to programs who request it. In addition, Wisconsin utilizes the annual Mental Health and Substance Use Recovery Conference and bi-weekly educational webinar organized by the Wisconsin DHS PCP staff to promote the use of recovery-oriented services and PCP. Nearly 11,000 providers, the majority of whom work in Wisconsin, are part of the educational webinar learning community.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

While Wisconsin does not currently have a specific statute for Psychiatric Advance Directives, consumers of public mental health services are provided with best practice resources to encourage the documentation of everyone's needs and choices for psychiatric care. When these conversations arise in addition to providing SAMSHA's Psychiatric Advance Directives guide, a consumer's choices in psychiatric decision making and care can be documented in crisis plans, safety plans, person centered plans, Wellness Recovery Action Plans (WRAP) and as an addition to Power of Attorney for Health Care (POA-HC) documentation. Any of the listed documents may outline a person's preferences for mental health treatment and care and best practice would encourage their distribution to all entities, family members and support systems identified by the consumer. Wisconsin's POA-HC statute allows an individual to appoint an agent to make healthcare decisions for that individual if they become unable to make decisions on their own. A POA-HC document can include mental health care. If a Health Care POA is enacted, it allows the health care agent to interpret mental health preferences during a crisis. If a client is interested in drafting a legal Psychiatric Advance Directive, they would be encouraged to work with a private attorney to draft one.

6. Please indicate areas of technical assistance needs related to this section.

No TA is needed at this time.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   None at this time.
4. Please indicate areas of technical assistance needs related to this section.

   None at this time.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 use primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ○ Yes ◉ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☑ Archival indicators (Please list)

Treatment Admissions

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

SUPTRS BG funds are allocated based on a statutory formula that determines the amount each county receives through Community Aids funding. By law, at least 20% of this funding must be directed toward primary prevention services. In addition to county allocations, we also issue funding opportunities that support a variety of prevention programs. Needs assessment data plays a critical role in guiding these funding decisions and shaping the direction of prevention efforts.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 use primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The Wisconsin Department of Safety and Professional Services oversees the credentialing process for substance use disorder Prevention Specialists.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

DHS, DCTS administers five regional prevention training and technical assistance centers through the Alliance for Wisconsin Youth coalitions statewide to support capacity building activities for the primary prevention workforce.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ( ) Yes (●) No

a) If yes, please describe mechanism used.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 use primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

See the attached plan titled, "Primary Prevention-SCAODA Strategic Plan and Goals_2023-27".

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [ ] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ( ) Yes (●) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

N/A

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 use primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- **a)** Information Dissemination:

  Information Dissemination: Brochures, clearinghouse/ resource centers, health fairs, media campaigns, hotlines, speaking engagements.
- **b)** Education:

  Education: Education programs for youth, mentors, ongoing classroom sessions, parenting/family management, peer leaders/helpers.
- **c)** Alternatives:

Alternatives: Recreation activities, community service activities, community drop-in centers, drug and alcohol-free dances and parties, youth/adult leadership activities.

d) Problem Identification and Referral:

Problem Identification and Referral: In Wisconsin, counties and providers are required to screen individuals engaged in substance use behavior to determine whether their behavior can be mitigated through education or other assistance without the need for treatment. Section DHS 75.14 provides standards for community-based prevention substance use services. Specifically, DHS 75.14 (5) states: Problem identification and stand-alone referral. The prevention service shall implement methods to identify individuals who have demonstrated at-risk behavior, such as illegal or age- inappropriate use of tobacco or alcohol, or first use of illicit drugs, and determine if the individual's behavior can be reversed through education. This strategy does not include activities designed to determine if a person is in need of treatment. Examples of activities that may be conducted and methods used in carrying out this strategy include the following: employee assistance programs, student assistance programs, and educational programs for individuals charged with driving while under the influence or driving while intoxicated.

e) Community-Based Processes:

Community-Based Processes: Community and volunteer training, community team building, coalitions, and systemic planning.

f) Environmental:

Environmental: Revised alcohol, tobacco, and drug policies in school, changes to alcohol and tobacco advertising

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

Subrecipients report their use of primary prevention set-aside grant funds in the SSA-developed annual grant reporting tool, including the amount of funds spent for prevention services and the percentage of the total SUPTRS Community Aids grant awards that is spent for prevention. Use of funds are reviewed for compliance with the various SUPTRS block grant requirements as well as other federal and state requirements.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 use primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders 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;
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4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in WebBGAS

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☐ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☐ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

State Council on Alcohol and Other Drug Abuse (SCAODA)

Four-Year Strategic Plan: 2023-2027

SCAODA Mission Statement: Provide leadership and direction on substance use and misuse in Wisconsin by serving as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on substance use and prevention issues, and promote collaboration across multiple sectors to advance and monitor progress of SCAODA's goals.

SCAODA Primary Goals and Objectives for 2023-27

1. Change Wisconsin's cultural norms and policies to transform the state's substance use and misuse challenges into healthy outcomes.

Objectives:

(a) Seek to reduce stigma associated with seeking and obtaining services for substance use and misuse.

(b) Promote environmental policies to reduce substance use and create more support and understanding of those in recovery and those who need treatment.

2. **Educate people of Wisconsin on the social, economic, and health impacts of substance use and misuse; as well as the benefits of effective prevention, harm-reduction, treatment, and recovery services.**

Objectives:

(a) The council will continue to fulfill its responsibility to provide leadership and coordination by promoting and advocating best-practices and policies for prevention, harm reduction, treatment, and recovery among all levels of government and in communities.

3. **Advocate for policies, adequate funding, capacity, and infrastructure to implement effective outreach, prevention, harm reduction, treatment, and recovery services for all in need.**

Objectives:

(a) Expand prevention, treatment, and recovery interventions and supports across the lifespan.

(b) Increase focus and resources for prevention, treatment, and recovery services for children, youth, transitional youth, and young adults

(c) Continue revitalizing the Children, Youth and Family Treatment Sub-Committee.

(d) Build awareness and capacity to identify and address the changing needs of older adults due to substance use and misuse.

(e) Enhance and expand capacity within the substance use workforce to better understand and address the diverse needs of higher risk and underserved populations, including those with language and cultural barriers - as recommended in the CLAS.

(f) Advocate for and support increased utilization of evidence-based interventions like SBIRT in schools, workplaces, health care, and communities.

(g) Advocate for and support adoption of innovative policies and promising practices and programs in substance use and misuse prevention, treatment, harm reduction, and recovery.

(h) Support and advocate for increasing the state excise tax on alcoholic beverages to the median tax level nationally, and increase the portion of tax revenue allocated for prevention, treatment, harm reduction, and recovery programs.

4. **Reduce health disparities and inequities, recognize and rectify historical trauma, and address biases within systems, policies and practices.**

Objectives:

(a) Improve the effectiveness of substance use prevention, treatment, harm reduction, and recovery services in addressing the needs of higher risk and historically underserved populations.

(b) Expand scope of prevention, treatment, harm reduction, and recovery services to be inclusive of populations most impacted by social drivers of health - including socioeconomic standing, zip code, legal status, and other health disparities.

(c) Support research and identification of substance use and misuse risk and protective factors.

(d) Advocate for and support the adoption of innovative and promising practices and programs across the continuum of care that fully integrate the National CLAS Standards.

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Wisconsin provides several community-based behavioral health programs to provide support outside of inpatient or residential institutions. Community Recovery Services (CRS) help individuals living with mental illnesses reach their full potential. Service providers and the consumer work together to improve the individual's quality of life in the community through an outcomes-based planning and support process focused on the individual's unique recovery needs. CRS includes three services:

1. Community living supportive services: These services include activities intended to assure successful community living, such as meal planning/preparation, household cleaning, personal hygiene, medication reminders, medication side effect monitoring, parenting skills, and community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills.

2. Peer support services: These services include assistance from an individual who has lived the experience of mental illness and is trained to support others in their recovery journey.

3. Supported employment services: These services include activities to assist individuals to obtain and maintain competitive employment.

Community Support Programs (CSP) are for adults living with serious and persistent mental illnesses. CSP provides coordinated professional care and treatment in the community that includes a broad range of services to meet individual's unique personal needs, reduce symptoms, and promote recovery. CSP is designed to provide services that can be tailored to the individual’s needs at any given time, ranging from minimal to intensive, or a level that might otherwise require care in a hospital setting. The goal is of the CSP is to reduce the need for repeated treatment and prolonged care in hospital settings. Each individual entering a CSP is assigned a case manager who develops a treatment plan with the individual, provides support and outreach, and assists in coordinating other services. CSP uses a team model to deliver services. This team includes a psychiatrist, nurse, and other support team members. Services may include assistance in daily living skills, group therapy, work adjustment training, social and recreational opportunities, and education regarding a person’s mental illness.

Comprehensive Community Services (CCS) are for individuals of all ages who need ongoing services for mental illnesses, SUDs, or a dual diagnosis beyond occasional outpatient care, but less than the intensive care provided in a CSP or inpatient setting. The individual works with a dedicated team of service providers to develop a treatment and recovery plan to meet the individual's unique needs and goals. The goal of this community-based approach is to promote better overall health and life satisfaction for the individual. CCS became available to counties and Tribal nations in Wisconsin in 2005. In 2014, the state provided counties and Tribal nations a financial incentive to form regions to increase access to CCS and create efficiencies in administration.

Presently, there are 25 certified regions. These regions cover 66 counties and three Tribal nations. One county provides CCS in a non-regional model. Eligibility for CCS is determined through a screening process conducted by the county-based or Tribal-based provider organization. This screening process is repeated annually to assess the individual's progress. CCS is built around proven treatment and support methods. The programs offered through CCS are designed to promote and support recovery by stabilizing and addressing an individual's critical MH/SUDe concerns, including an individual's ability to self-manage their physical and social health; and an individual's ability to meet their basic needs, including housing, education, and employment skills.

Coordinated Services Team (CST) initiatives are programs designed to provide wraparound support to children struggling to maintain their emotional, physical, and social well-being because of multiple and serious challenges in their lives. CST initiatives

are designed to develop a comprehensive, individualized system of care for children with complex behavioral health needs. The CST team is a group that includes family members, service providers, and others who work to develop and carry out a coordinated services plan for the child. CST initiatives are intended for children who are involved in multiple systems of care such as MH, SUD, child welfare, juvenile justice, special education, and developmental disabilities.

Collectively, these programs provide a robust system of community-based behavioral health services through Wisconsin's public behavioral health system.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	● Yes	○ No
b)	Mental Health	● Yes	○ No
c)	Rehabilitation services	● Yes	○ No
d)	Employment services	● Yes	○ No
e)	Housing services	● Yes	○ No
f)	Educational services	● Yes	○ No
g)	Substance use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	● Yes	○ No
i)	Recovery Support services	● Yes	○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes	○ No
k)	Services for persons with co-occuring M/SUDs	● Yes	○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

As described above, case management services are provided through Wisconsin's psychosocial rehabilitation programs CCS and CSP. Many county-based providers also provide Targeted Case Management (TCM) services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

In addition to Wisconsin's robust array of community-based behavioral health programs, the state supports several initiatives intended to reduce hospitalization. One key initiative is Wisconsin's crisis intervention programs. Crisis programs provide both emergency responses to an emergent situation as well as anticipatory crisis planning. Programs are required to provide linkage, coordination, and follow-up services. As a result, these programs make referrals and connect individuals and their families to mainstream resources to stabilize a crisis situation and to prevent the emergence of another. Crisis services have enabled diversion from many unnecessary psychiatric hospitalizations.

Another key initiative in Wisconsin is a series of peer run respites. These respites are for individuals living with MH/SUD concerns and offer a supportive, home-like environment during times of increased stress or symptoms. Stays are short-term, typically no longer than one week. Peer run respites are managed and staffed by individuals living with MH/SUD concerns who themselves have been successful in recovery. Peer run respite services are designed to aid in the individual's recovery and avert crises and avoid hospitalizations.

5. Please indicate areas of technical assistance needs related to this section.

None at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	6.0	
2.Children with SED	11.0	

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The number of adults and children with SMI/SED is estimated using the Wisconsin-specific adult rates from the National Survey of Drug Use and Health and the national children's rates from the NIMH Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. Wisconsin does not currently have an estimate of statewide incidence. Prevalence rates are utilized in Wisconsin's needs assessments.

3. Please indicate areas of technical assistance needs related to this section.

Wisconsin is interested in learning how other states calculate statewide incidence.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

None at this time.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

Rural areas of Wisconsin mirror national patterns of shortages of MH professionals. This lack of MH professionals, particularly for children and adolescents, has resulted in frequent difficulty finding a psychiatrist for many residents. To increase capacity, particularly in rural areas, Wisconsin continues to support several efforts. Key efforts to increase capacity have been the expansion of CCS and CST programs throughout the state. In particular CCS expansion is encouraged in a regional model, allowing counties to pool resources to better serve their residents. For rural older adults with both long-term care needs and behavioral health treatment needs, the state's Medicaid home and community-based waiver program, Family Care, provides an integrated treatment and support delivery system through Managed Care Organizations (MCOs).

The use of peer specialists is another key initiative Wisconsin utilizes to increase capacity. This includes a dual diagnosis Certified Peer Specialist certification and a Parent Peer Specialist certification.

The increased use of telehealth in Wisconsin has helped to address the need for an array of MH/SUDe services. Psychiatry services in particular are lacking in many rural areas. To help address these barriers, Wisconsin supports a Child Psychiatry Consultation Program to provide support to physicians. In this model, the primary care physician provides direct patient care supported with a child psychiatric consultant.

Wisconsin also offers the Wisconsin Farmer Wellness Helpline, which helps Wisconsin farmers who may be experiencing a MH crisis. This helpline was created as a collaborative effort between the Wisconsin Department of Agriculture, Trade, and Consumer Protection, and the Wisconsin Department of Health Services (DHS).

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

In Wisconsin, the goal is to affirm the right of individuals with serious and persistent mental illnesses and people with serious SUDs 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 illnesses and SUDs often go from one emergency system to another. Studies show it is more cost effective to house someone in stable, supportive housing than to relegate them to homelessness, mired in the revolving door of high-cost crisis care and emergency housing.

Wisconsin provides a range of services to those who are homeless or are at risk of homelessness. The HOME Tenant-Based Rental Assistance (TBRA) program is offered through the Department of Administration's (DOAs) Division of Housing with a HUD- funded Emergency Solutions Grant (HEARTH 24 CFR part 91 and 576) and through state-funded shelter, transitional living, and homelessness prevention grants. 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. Having related medical insurance significantly improves access to medical and behavioral health treatment. One critically important program in Wisconsin is the Projects to Assist in the Transition from Homelessness (PATH) supported by Substance Abuse and Mental Health Services. The goal of PATH is to locate and engage people experiencing homelessness who have mental illnesses or co-occurring disorders to facilitate enrollment in PATH services.

The Bureau of Prevention Treatment and Recovery (BPTR) collaborates with the Department of Veterans Affairs (DVA) to address homelessness in urban areas. BPTR coordinates care connections between DVA hospitals and regional veterans' offices. The 988 Wisconsin Lifeline answers calls from veterans regularly, some of whom are homeless, and makes referrals for housing, and MH/SUDe services.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

Wisconsin has infrastructure in place to provide long-term care to persons who have disabilities 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 some community MH/SUDe treatment services form some members including outpatient and CSP 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 design their own support and service network. These programs are connected to the Aging and Disability Resource Centers (ADRCs), which serve as the entry point for people who may need supportive community services.

d. Please indicate areas of technical assistance needs related to this section.

None at this time.

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

The Bureau of Prevention Treatment and Recovery (BPTR) is the State Mental Health Authority (SMHA) and Single State Agency for Substance Abuse (SSA). Wisconsin is a home rule state, with county government having responsibility in state law for MH/SUDe prevention and treatment services for those without other resources. The BPTR administers its public community MH/SUD system through 67 county programs per state statute Chapter 51. The public system is built upon a state-county partnership reflected by shared funding of county-administered programs. The BPTR is responsible for the following:

- Grants management and contract administration for Federal Block Grants and discretionary grants;
- Development and technical assistance for the Mental Health and Substance Use Administrative Rules and State Statutes;
- Contract administration for Community Mental Health and Substance Use grants and services;
- Staff support to the State Councils (State Council on Alcohol and Other Drug Abuse and Wisconsin Council on Mental Health);
- Planning, Development, and Provision of Technical Assistance for the Public Mental Health/Substance Use Services System.

Financial management is conducted by the BPTR in collaboration with the Bureau of Fiscal Services (BFS). The DHS uses the Department of Administration (DOA) accounting system called STAR (State Transforming Agency Resources) which uses PeopleSoft Enterprise Resource Planning software from Oracle. The DOA through its State Controller's Office (SCO) maintains the State's accounting system. This system provides the financial data necessary for the financial management and control of all state accounts. The SCO also maintains the general ledgers for all funds of the state. The accounting policies and procedures are consistent with state laws and are in accordance with 45 CFR Part 95.507(b)(4). Cost incurred directly by DHS are supported by appropriate vendor and accounting records.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Wisconsin uses telehealth across the majority of MH services in the state. During the pandemic, many flexibilities were created to assist providers to use telehealth when services could be offered in a manner similar to a face-to-face interaction. These flexibilities were written into program administrative code and Medicaid policy as permanent allowable services in most program areas after the conclusion of the pandemic. Recent efforts to expand access to providers includes an increase in telehealth services in Wisconsin, including a state-funded Child Psychiatry Consultation Program to provide support to physicians in two programs, one rural and one urban. Through this program, a child psychiatrist is available via phone to consult with a pediatrician or other primary care physician to support them in providing MH treatment in the primary care office.

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	● Yes	○ No
ii)	Education	● Yes	○ No
iii)	Brief intervention	● Yes	○ No
iv)	Assessment	● Yes	○ No
v)	Withdrawal Management (inpatient/residential)	● Yes	○ No
vi)	Outpatient	● Yes	○ No
vii)	Intensive outpatient	● Yes	○ No
viii)	Inpatient/residential	● Yes	○ No
ix)	Aftercare/Continuing Care	● Yes	○ No
x)	Recovery support	● Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	● No
ii)	Adolescents?	● Yes	○ No
iii)	Older Adults?	● Yes	○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Wisconsin Department of Health Services (DHS) uses several strategies to monitor and identify compliance issues related to activities and services for PWWDC. Contract administrators maintain regular communication with their programs and grantees, providing technical assistance and supporting implementation of best practices to achieve program and performance goals. Grantees submit mid-year and annual performance reports, and contract administrators complete an annual risk assessment for each grantee. Additionally, staff conduct annual or periodic on-site visits with the various contract vendors to further monitor programs, progress toward meeting goals and objectives, and challenges or obstacles. These multiple strategies are used by staff to discuss necessary program refinements and corrective actions to improve program performance. In addition, the Division of Care and Treatment Services (DCTS) receives annual reports from counties that require them to address whether they are complying with SUPTRS BG requirements, and what corrective actions were taken in instances where counties were out of compliance.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement? (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services? (●) Yes ( ) No
- **c)** Outreach activities? (●) Yes ( ) No
- **d)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached? (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement? (●) Yes ( ) No
- **c)** Use of peer recovery supports to maintain contact and support? (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Within the DCTS, designated staff within the substance use services section receive notification of 90 percent capacity and provision of interim services from providers across the state. In addition, the DCTS receives annual reports from counties that require them to address compliance with the various SUPTRS BG requirements, and what corrective actions were taken in instances where counties were out of compliance. In addition to ensuring counties have processes in place for reporting wait lists and capacity, requirements are communicated in contracts and via ongoing communications from the DCTS.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers? (●) Yes ( ) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment? (●) Yes ( ) No
- **c)** Established co-located SUD professionals within FQHCs? (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

As part of annual reports submitted to the DCTS, counties are required to address whether they are complying with SUPTRS BG requirements, including tuberculosis-specific requirements. Additionally, DHSs Division of Quality Assurance (DQA) assesses behavioral health providers for compliance with tuberculosis-specific requirements as part of licensing certification, including what corrective steps were taken to meet compliance in instances where providers were previously cited for being out of compliance.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ( ) Yes (●) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas?	○ Yes	● No
b)	Establishment or expansion of tele-health and social media support services?	○ Yes	● No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?	○ Yes	● No

Hypodermic Needle Prohibition

1.	Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?	● Yes	○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? ( ) Yes (●) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records? ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Five to six block grant sub-recipients are reviewed each year.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review? (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? (●) Yes ( ) No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ● No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ● Yes ○ No

c) Performance-based accountability? ● Yes ○ No

d) Data collection and reporting requirements? ● Yes ○ No

If the answer is No to any of the above, please explain the reason.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? ● Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ● Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ● Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) SMI Adviser ● Yes ○ No

c) Addiction TTC? ● Yes ○ No

d) State Opioid Response Network? ● Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ● Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ● No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://docs.legis.wisconsin.gov/code/admin_code/dhs/030

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

   Counties report their participant and service data to the Program Participation System (PPS) online data collection system. This data includes participant information and demographics; each service they receive including date, type of service, and provider; and outcome data (NOMS) that are entered every 6 months. Counties are required to report MH/SUDe services that they authorize, or which have been paid for with federal, state, or county funds or revenue.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

This system is specifically to collect county MH/SUDe services. It was originally designed around SAMHSA MH-CLD, URS, and TEDS reporting requirements; the data structure and field elements are based on those requirements.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

BPTR is able to analyze data linking PPS MH/SUDe participants to their Medicaid claims data. There is no current integrated system (besides that the data sets are located in the same data warehouse). Linking the data occurs ad hoc as analysis needs arise.
BPTR can also link PPS data to Mental Health/Substance Use Functional Screen data which provides another source of status and outcome data on subset of PPS participants.
In addition, there is an initiative in progress to add PPS employment data to the Competitive Integrated Employment (CIE) data set that was created through the 2017 Wisconsin Act 178. This data set combines employment from the Department of Health Services (DHS), Department of Public Instruction (DPI), and Department of Workforce Development (DWD) to coordinate services that ensure individuals with disabilities have access to competitive integrated employment opportunities.
BPTR does not link PPS data on an individual level to any other data set.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

Evidence-based practices (EBP) data is not collected in PPS. BPTR previously had county MH programs annually report aggregate data on the EBPs that they use (on a program survey their programs would complete). However, since many services are contracted out by the county, they have difficulty reporting this; therefore, due to lack of reliability and availability, BPTR no longer reports on EBPs.

A participant's enrollment in a Coordinated Specialty Care program (which provides service to individuals with ESMI) is not recorded in PPS. The counties that have Coordinated Specialty Care programs previously submitted spreadsheets with individual participant data on a quarterly basis. These were difficult to manage and often were inconsistent or incomplete. Last year, programs began entering their client data into EPINET. BPTR must submit a request to the website to access the data.

Counties submit their crisis services to PPS, but since the services are often one-time or very short-term, counties do not submit client outcome data such as living situation, employment, etc., for these participants. If a participant is receiving long-term services while receiving crisis services, BPTR would have outcome data for that individual.

5. Briefly describe the limitations of the SMHA 's existing data system.

The current data collection structure as well as certain individual fields are not aligned with current reporting requirements or business practices of counties. This causes confusion and frustration regarding the data submission process as well as inconsistency in data. Also, the batch file submission process is not user-friendly which results in a lot of staff time to troubleshoot errors, especially when a county updates their electronic health record (EHR). Moreover, the management of PPS is contracted to a private vendor, which means any updates to the system can be costly.

PPS only collects county services which means any services from private providers who are not county-contracted, whether the service was paid for with public dollars, are not captured. Also, some services, even though they may fall under the purview of the county MH system, are difficult for the county staff to track and enter, such as emergency detentions and some residential and inpatient services. This limits the utility of the data.

6. What strategies are being employed by the SMHA to enhance data quality?

PPS is an outdated system and needs to be migrated to a modern platform. BPTR has been working on this project for several years, but so far, it has been too costly to pursue. Once BPTR can upgrade the system, BPTR will redesign the system to make it more user-friendly and align it with current business practices and reporting requirements.

In the meantime, BPTR is conducting a data quality initiative in which BPTR is communicating with all counties about their PPS data and checking its accuracy. In this process BPTR is addressing various data submission issues that counties may or may not have been aware of. Shortly, BPTR will initiate a quarterly data quality check in which each county can review its data for that quarter and check for any issues.

In conjunction with this, BPTR has recently created several data quality reports counties can run on their own through the data warehouse. These will be referenced in the data quality quarterly checks, while counties can monitor their own submissions at any time.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

As described above, the PPS data collection system is out-of-date and is currently too costly to upgrade though BPTR continues to explore options. BPTR has a limited number of data evaluators, and managing and reporting PPS data is only a part of their job responsibilities. This limits the ability to conduct more comprehensive data quality improvement efforts.

In the larger picture, the structure of the public behavioral health system in Wisconsin in which counties administer the services continually presents challenges in reporting as each county has its own EHR, policies, and procedures. It is difficult to collect consistent comparable data across the state and to provide comprehensive support to 72 different systems.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

In Wisconsin, Crisis Intervention, administered under DHS 34, subchapter III administrative rule, is available through three modalities, at minimum: 24/7 telephone services; 8 hours per day, 5-days per week walk-in service; and 8-hours per day, 7-days per week mobile services. Programs certified under subchapter III are eligible to claim reimbursement for service provision through Wisconsin Medicaid through an established fee-for-service rate structure and private insurers as well (Wisconsin administrative rule requires Crisis Intervention Services to be covered under Casualty Insurance: INS 3.37). 65 of Wisconsin's 72 counties have programs certified under DHS 34, subchapter III. Certified counties provide the services themselves, contract with a private agency or other county to provide the services, or a combination of both. Crisis stabilization services

are an optional service which certified programs may provide and receive reimbursement for. In Wisconsin there are approximately 23 crisis stabilization facilities, five regionalized crisis stabilization facilities that are supported through DHS grant funds, and three certified youth crisis stabilization facilities, two of which are supported through DHS grant funds.

There is one urban county and five urban counties that do not participate in subchapter III services, yet all Wisconsinites have access to crisis call center services through the 988 Wisconsin Lifeline. Additionally, all counties, regardless of certification are responsible for the coordination of emergency mental health care for individuals in need of involuntary psychiatric placement and/or commitment. Eligibility for subchapter III crisis service is broadly defined as "a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual." Wisconsin Crisis programs are also responsible for preparing and implementing a "Response Plan" for all individuals enrolled and provided services in the Crisis Program. Additionally, a "Crisis Plan" is created for "an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs." Thus, Crisis programs provide both emergency responses to an emergent situation as well as anticipatory crisis planning.

In Wisconsin, crisis intervention is administered under DHS 34, subchapter III administrative rule. It is available through three modalities, at minimum: telephone services, 24/7; walk-in services, 8 hours per day, 5 days per week; and mobile services, 8 hours per day, 7 days per week. Programs certified under subchapter III are eligible to claim reimbursement for service provisions through Wisconsin Medicaid using an established fee-for-service rate structure and private insurance. Wisconsin administrative rule requires crisis intervention services to be covered under Casualty Insurance: INS 3.37. Of Wisconsin's 72 counties, 65 have programs certified under DHS 34, subchapter III. Certified counties provide the services themselves, contract with a private agency or other county to provide the services, or a combination of both. Crisis stabilization services are an optional service certified programs may provide and receive reimbursement for. There are approximately 23 crisis stabilization facilities throughout Wisconsin, five regionalized crisis stabilization facilities, and three certified youth crisis stabilization facilities (YCSFs) which are supported through DHS grant funds.

There are five rural counties and one urban county that do not participate in subchapter III services; however, all Wisconsinites have access to crisis call center services through the 988 Wisconsin Lifeline. Additionally, all counties, regardless of certification, are responsible for the coordination of emergency MH care for individuals in need of involuntary psychiatric placement and/or commitment. Eligibility for subchapter III crisis service is broadly defined as "a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual." Wisconsin crisis programs are also responsible for preparing and implementing a "response plan" for all individuals enrolled and provided services in the crisis program. Additionally, a "crisis plan" is created for "an individual at high risk of experiencing a MH crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs." Thus, crisis programs provide both emergency responses to an emergent situation as well as anticipatory crisis planning.

Programs are required to provide linkage, coordination, and follow-up services. Consequently, these programs are making referrals and connecting individuals and their families to other resources to stabilize a crisis and to prevent the emergence of another. Crisis services have enabled diversion from many unnecessary psychiatric hospitalizations. In Wisconsin, for an individual to be involuntarily hospitalized under an emergency detention, the county department of community programs must provide a "crisis assessment" and approve the transfer to a treatment facility. In almost all cases, that authority is with the crisis intervention program, delegated to a MH professional, Wisconsin Stats. Chapter 51.15 (2) (c). This requirement affords an opportunity to evaluate the necessity for a hospitalization or alternatively to employ a more trauma informed, least restrictive alternative such as a community safety plan or a crisis stabilization option, either in-vivo or in a residential setting.

Stabilization in place or use of facility-based, residential stabilization resources are optional services for Subchapter III certified programs. Many counties have residential stabilization facilities for adults. They include one or two-bed county-licensed Adult Family Homes (AFHs) or larger three or four-bed AFHs or five to 16-bed state-licensed Community-Based Residential Facilities (CBRFs). Regionalized crisis stabilization facilities (RCSFs) are currently operating in all five regions of the state, however; based on geography, they may not serve all counties within the region. Of Wisconsin's 72 counties, 45 have an active contract with at least one RCSF. Additionally, there are three operating, certified, YCSFs in the state which provide short term, crisis stabilization services for youth. Of Wisconsin's 72 counties, 34 have active contracts with at least one YCSF.

Regionalized crisis stabilization facilities (RCSF) are currently operating in all five regions of the state however, based on geography may not serve all counties within the region. These RCSFs are partially funded through a DHS grant. 45 out of 72 of Wisconsin's counties have an active contract with at least one regional crisis stabilization facility. Additionally, there are three operating, certified, youth crisis stabilization facilities in the state which provide short term, crisis stabilization services for youth. 34 out of 72 of Wisconsin's counties have active contracts with at least one youth crisis stabilization facility.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

Someone to talk to: Crisis call Capacity

Number of locally based crisis call lines in state

Of Wisconsin's 72 counties, 65 have Medicaid reimbursable, certified crisis programs that are required to operate crisis call lines. These call lines provide 24-hour, 7 days a week phone support, information, counseling, intervention, emergency service coordination, and referrals to individuals and families in crisis. In the 988 Suicide and Crisis Lifeline network, Wisconsin has one primary 988 Suicide and Crisis Lifeline center that answers all calls, chats and texts. The 988 Wisconsin Lifeline and one backup center are both operated by Family Services of Northeast Wisconsin.

Number of crisis call lines with follow up protocols in place
All 65 of Wisconsin's DHS 34 certified crisis programs are required to provide linkage, coordination, and follow-up services to persons in crisis as needed and appropriate which may be outlined in their emergency MH services written plan for providing coordinated emergency MH services within the county. The 988 Wisconsin Lifeline provides referrals to community services for calls, chats, and texts based on the context of the call and need for follow up. The help seekers consent is required to provide these services.

Percent of 911 calls that are coded out as BH related
Wisconsin currently does not collect data on 911 calls that are coded out as being behavioral health related. Based on a nationwide report, "one recent analysis of eight cities found that between 21 and 38 percent of 911 calls are related to MH, SUD, homelessness, and other quality of life concerns".

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

Of Wisconsin's 72 counties, 90% have Medicaid reimbursable, certified crisis programs which require them to have mobile crisis services available for at minimum, 8 hours a day, 7 days a week during a period of time identified in their emergency MH services plan when mobile services would be needed most. On January 1, 2024, county crisis programs began to have the option to enroll with Medicaid to receive an enhanced benefit which allows billing for a team of up to three mobile crisis providers. One requirement to receive the enhanced benefit is to have mobile crisis teaming available 24 hours a day, 7 days a week. There are currently six counties enrolled as enhanced programs and additional counties billing through the teaming benefit.

Independent of first responder structures (police, paramedic, fire)
All of Wisconsin's mobile crisis programs are independent of first responders; however, many of these programs work closely with first responders and many referrals come from law enforcement. Based on a 2022 crisis survey, of all the mobile crisis responses that occurred in 2022 where law enforcement was not the referral source, the average requested law enforcement accompaniment was 52.2%.

Integrated with first responder structures (police, paramedic, fire)
This was not a data point collected on the 2022 crisis survey. Currently, law enforcement agencies in 21 counties partner with their county crisis provider and utilize a formal co-responder program.

Number that employs peers
Based on 2022 crisis survey data, the following data shows the number of counties (out of 72 in Wisconsin) who utilized various peer supports in county crisis programs (calls, mobile response, crisis stabilization):
i. Certified peer specialists (CSPs) = 12 | (17.65%)

ii. Non-certified peer supports = 5 | (7.35%)
iii. Certified parent peer specialists = 2 | (2.94%)
iv. Recovery coaches (RCs) = 9 | (13.24%)
v. No peer supports used = 46 | (67.65%)

In 2023, the Wisconsin Department of Health Services (DHS) conducted a peer crisis work survey which directly captured real time workforce data representing Wisconsin's peer workforce in behavioral health, with a focus in crisis. The survey captured data from individuals with lived experience including CPSs, RCs, and uncertified individuals. The survey concluded December 2023 and an official report was published in 2024.

Key findings of the survey are as follows:

Peer identities
· 55% of survey respondents identified as a CPS, 22% RC, and 13% dually certified.
· Of those who did not identify as a CPS, the top reported barriers to certification included access to trainings and difficulties with the application process.
· 63% of survey respondents had 20+ years of lived experience.
· 89% of survey respondents had lived experience in MH/SUD crisis.

Peer work experience
· About two-thirds had been employed full-time providing peer services for five years or less.
· The average hourly rate of pay was $20.40.
· 30% of people working in the peer field had secondary employment.
· The top reasons for leaving the peer field included lack of a living wage, career advancement, and employer support.

Peer crisis services experience
· 81% of survey respondents had experience working with people in MH/SUD crisis.
· 65% or more were interested in working throughout the entire Crisis Now Model. Someone to talk to – 65% interest; someone to respond – 73% interest; a safe place to go – 80% interest; community intensive follow up – 82% interest.
· People who experienced involuntary or voluntary hospitalization for MH/SUD concerns had the highest level of consideration for working in peer roles supporting people experiencing related hospitalizations.

The peer workforce data allowed DHS to respond to immediate needs and barriers highlighted in the survey results. Wisconsin DHS recently conducted an additional survey in 2025, aimed at parent peers, to understand the statewide landscape as it relates to parent peer supports in crisis work. This data is still in the process of being published.

Peers provide crisis services within some Wisconsin county services, including mobile crisis units. Additionally, CPSs provide services at all five Wisconsin RCSFs. Certified Parent Peer Specialists also provide crisis services in youth crisis programming throughout multiple counties in Wisconsin.

Safe place to go or to be:
Number of Emergency Departments
• 2025 data shows that Wisconsin has 141 hospitals with emergency departments.

Number of Emergency Departments that operate a specialized behavioral health component.
• Wisconsin has one psychiatric emergency hospital located in Milwaukee.
• Emplify Health in La Crosse is planning on opening an EmPATH unit in December 2025.

Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

Wisconsin has approximately 23 crisis stabilization facilities that are county operated or directly contracted by counties. Most of these crisis stabilization facilities are licensed as CBRFs or AFHs to provide short-term, billable, community-based crisis services to clients. There are an additional five adult regional facilities, RCSFs. Wisconsin has three YCSFs certified under DHS 50, which are partially funded through DHS grants.

In June 2025, Wisconsin published an emergency administrative rule for the certification of crisis care facilities. These new facility types in Wisconsin are designed to serve voluntary and involuntary people in crisis. They will have 24/7 urgent care, walk-in services, observation capabilities, and stabilization for up to five days. Wisconsin anticipates the publication of the permanent rule order in spring 2026. Funds were recently allocated in the Wisconsin state budget to support the development and implementation of 1-2 crisis care facilities.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Wisconsin continues to develop and enhance the state's crisis system based on the Crisis Now model and guidelines developed by SAMHSA. The 988 Wisconsin Lifeline is one area of focus as it's often the initial touchpoint for individuals in crisis. With 988 now entering its fourth year of operation in Wisconsin, we continue to focus on the integration of 988 within the Wisconsin's broader system of care, especially as it relates to public safety answering points, mobile crisis dispatch, and facility-based crisis stabilization services. With mobile crisis response available in most of the state, there is focus on enhancement of these services which include mobile crisis teaming response, response in rural and underserved

areas or underserved populations, 24/7 response, and enhanced follow-up. Crisis stabilization efforts in Wisconsin are being enhanced through two new facility types. Crisis Care Facilities, which will be certified under the new administrative code, DHS 31, offers 24/7 walk in and stabilization services for voluntary and involuntary people in crisis AND crisis hostels, which will be certified under DHS 33 and provide community based voluntary care for persons in crisis for less than 24 hours. Crisis Care Facilities will be Medicaid reimbursable and be able to operate and bill Medicaid external to counties, which is a big step forward from our county-based system.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 65
   ii. Not in the suicide lifeline network: 7

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 65
   ii. Not in the suicide lifeline network: 7

c. Estimated percent of 911 calls that are coded out as BH related: 30

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 68

b. Integrated with public safety first responder structures (police, paramedic, fire): 21

c. Number that utilizes peer recovery services as a core component of the model: 74

Safe place to be

a. Number of Emergency Departments: 141

b. Number of Emergency Departments that operate a specialized behavioral health component: 1

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 23

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

100% of the 5% set aside is going to support the 988 Wisconsin Lifeline.

7. Please indicate areas of technical assistance needs related to this section.

Wisconsin requests technical assistance regarding sustainable funding for 988 and Crisis Care Facilities.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

There are many peer-run agencies in Wisconsin that have at least 51% of board members with serious mental illnesses (SMIs) and staff with SMIs. These include peer-run recovery centers, peer-run respites, and a peer-run agency. There are two peer advisory committees at the Wisconsin Department of Health Services (DHS). The Recovery Implementation Task Force (RITF) is an advisory board to the DHS Division of Care and Treatment Services (DCTS). The role of the RITF is to ensure Wisconsin's MH/SUD services promote recovery, hope, dignity, and empowerment throughout the lifespan. Members include individuals with lived experience of a mental illness and/or SUD and advocates for individuals with these concerns.

The Certified Peer Specialist Advisory Committee (CPSAC) advises DHS, DCTS, and the Bureau of Prevention Treatment and Recovery (BPTR) on the Wisconsin Statewide Peer Specialist Employment Initiative (WISPSEI). CPSAC serves BPTR in its support and oversight of the training, certification and support of peer specialists and parent peer specialists.

These peer-run programs have expanded for those who have MH/SUDs including dual disorder education, health care integration, and certified peer specialists in crisis services. There is movement toward self-directed care, shared decision-making, and person-centered planning.

In addition to the peer-run supports and services, the National Alliance on Mental Illness (NAMI) Wisconsin and their local affiliated organizations are a primary resource for recovery supports for people with mental illness and their families. NAMI Wisconsin advocates for better support, resources and recovery for all.

Wisconsin has support services offered through schools for children with SED in many areas. These can be in the form of NAMI supported groups and/or training in schools and communities to support youth in the decision regarding telling their own story. There is also support provided in the state for parents of children with SED from other parents through advocacy and support agencies such as Wisconsin Family Ties and NAMI.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Wisconsin has a variety of recovery support services accessible for individuals with SMI and SUD, including:
- peer-run recovery centers;
- peer-run respites;
- certified peer specialists;
- certified parent peer specialists;
- peer-run recovery advisory task force that focuses on peer specialists;
- peer recovery education;
- dual disorder education;
- health care integration;
- peer-run warmlines;
- recovery organizations;
- peer recovery coaching provided to individuals who have suffered an opioid overdose in an emergency room;
- peer recovery coaching;
- person-centered planning;
- self-care and wellness approaches
- support for women and their children while in treatment; and
- county-funded SUD treatment that includes room and board.

Wisconsin also has a network of Alcoholics Anonymous and Narcotics Anonymous meetings across the state.

DHS will publish an administrative rule for the standards and Medicaid reimbursement for peer recovery coaches to provide peer support and services in the Fall of 2025. This administrative rule will allow most certified MH/SUD programs to hire or contract with peer recovery coaches to provide integrated peer services via telehealth throughout the state and to receive payment for their services. While Wisconsin has had limited reimbursement for certified peer specialists and certified parent peer specialists for MH/SUDs, this will enhance the ability for agencies to locate and hire or contract with peers to provide peer recovery support.

5. Does the state have any activities that it would like to highlight?

None at this time.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

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[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

In 2023, Wisconsin held a Children's System of Care Summit. The purpose of the summit was to engage, equip, and empower

Tribal nations and counties in the evolution of their children's system of care. The summit was divided into three parts – inspire, inform, and implement. Prior to the summit, a tremendous amount of data collection was conducted and then this data was carefully evaluated. The summit participants included individuals with lived experience, peer services, counties, Tribal nations, primary care providers, advocates, and state representatives from child welfare, youth justice, education, corrections, and behavioral health. The summit laid the foundation for the 2024-2030 children's system of care strategic plan which contains five pillars;

1. Governance, funding, and state-local partnerships
2. Public health approach: health and MH integration
3. Crisis support, specialized residential services, and respite care
4. Parent and youth peer support initiatives
5. Workforce development

This plan will be monitored by the Children Come First Advisory Committee (CCFAC), a committee mandated by legislation, and the subcommittee formed to actualize the key results. The plan has been implemented across the children's system of care and routine reporting of progress occurs through the CCFAC and is shared at state-wide conferences, council, and committee meetings.

Wisconsin has guidelines for individualized care planning rooted in wraparound values and principles. Care coordinators build plans of care for children and youth based on information obtained from the Child and Adolescent Needs and Strengths (CANS) tool. The team and the family are involved in discussing each child's strengths and needs and prioritizing them. Once the top needs have been agreed upon, the development of the care plan begins with the identification of a long-term goal. The team then determines short-term goals, objectives, and tasks, and identifies the person responsible, timeline, and funding source for each goal. Plans of care must be updated every six months. In addition, crisis response plans for each child/youth are also required.

7. Does the state have any activities related to this section that you would like to highlight?

Wisconsin has been working towards creating a more seamless comprehensive children's behavioral health system and expanding work in the system of care after technical assistance was received by Georgetown University in 2015. The initial steps in this work included work to move the Wisconsin systems of care framework forward by infusing the Coordinate Services Teams (CST) Initiatives framework and best practices for working with children and families within Comprehensive Community Services (CCS) Program. A set of standardized goals has been established as a part of the workplan for CST sites to create consistent and collective improvement. These goals include three priority areas: quality wraparound care coordination, strong system of care development, and effectiveness/impact.

The work has evolved to include a system of care self-assessment tool that Tribal nations and counties can use to assess where they are at in the development of their local system of care. Tribal nations and counties use this information to develop a plan to improve specific areas of need. Additionally, this information is used by the state to make data-driven decisions in the provision and development of technical assistance. The tool is a published document that has been used by other states in the assessment of their local systems of care. Complex care coaching technical assistance is provided to organizations, systems, counties, and Tribal nations to aid a coordinated system response.

The state has also developed a resource library that serves as a companion to the self-assessment tool. The work that was done at the Georgetown Implementation Academy has been continued with the work that was done at the Children's System of Care Summit in 2023. From this summit, a statewide children's system of care strategic plan was completed in early 2024. Wisconsin has been invited to present at national conferences related to children's system of care as well as consult with other states on their own evolution and development.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

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12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

• Support a systems change approach (e.g., Zero Suicide framework) to prevent suicide for individuals receiving services in health or behavioral health care settings. This program currently runs through September 30, 2026, and DHS is working to determine whether it will continue or if alternatives will be developed.
• Develop the MH workforce through training in recognizing, assessing, managing, and responding to suicide risk.
• Train community partners on how to respond to someone with SMI/SED experiencing suicidal thoughts.
• Build coping skills and support networks for people with SMI/SED.
• Support a 988-member center that provides statewide coverage for 988.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ( ) Yes (●) No

If yes, please describe how barriers are eliminated.

NA

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? ( ) Yes (●) No

If so, please describe the population of focus?

NA

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority 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 any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

The DHS DQA and DMS work closely with DCTS to inform minimal standards, certification requirements, and reimbursement requirements for mental health services in the state. DQA and DCTS collaborate on TA, with DQA attending provider meetings and training to share trending information, and DCTS devising ways for providers to improve and address concerns. DQA and DMS facilitate communities of practice, focusing on adherence to standards. DCTS, DMS, and DQA identify liaisons at the programmatic level to work on systemic issues and to maintain routine meetings and communications.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

DHS has a history of collaboration with other Wisconsin state agencies, including Department of Public Instruction (DPI), Department of Children and Families (DCF), Department of Corrections (DOC), and Department of Justice (DOJ). These agencies work together to eliminate silos and to support initiatives focused on improving the efficiency, effectiveness, and quality of mental health services statewide through new initiatives, budget requests, and planning and discretionary grants. The relationship between DCTS and DOC comes from a shared understanding of the challenges of staffing correctional facilities with limited resources. Competency services are a priority within the DOC/DHS relationship. On a programmatic level, BPTR works with Veterans Affairs on programs to address homelessness and to support the 988-crisis line dedicated to veterans.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ○ No

b. State Report ○ Yes ○ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ○ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

7. Please indicate areas of technical assistance needs related to this section.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	0	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	0	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**0**	**0.00%**
6. State Employees	0	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**0**	**0.00%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**0**	**0.00%**
16. Total membership (all members of the council)	**0**	

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15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant 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 federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? ( ) Yes (●) No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) ( ) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

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Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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State Council on Alcohol and Other Drug Abuse (SCAODA)

Four-Year Strategic Plan: 2023-2027

SCAODA Mission Statement: Provide leadership and direction on substance use and misuse in Wisconsin by serving as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on substance use and prevention issues, and promote collaboration across multiple sectors to advance and monitor progress of SCAODA's goals.

SCAODA Primary Goals and Objectives for 2023-27
1. Change Wisconsin's cultural norms and policies to transform the state's substance use and misuse challenges into healthy outcomes. Objectives: (a) Seek to reduce stigma associated with seeking and obtaining services for substance use and misuse. (b) Promote environmental policies to reduce substance use and create more support and understanding of those in recovery and those who need treatment.
2. **Educate people of Wisconsin on the social, economic, and health impacts of substance use and misuse; as well as the benefits of effective prevention, harm-reduction, treatment, and recovery services.** Objectives: (a) The council will continue to fulfill its responsibility to provide leadership and coordination by promoting and advocating best-practices and policies for prevention, harm reduction, treatment, and recovery among all levels of government and in communities.
3. **Advocate for policies, adequate funding, capacity, and infrastructure to implement effective outreach, prevention, harm reduction, treatment, and recovery services for all in need.** Objectives: (a) Expand prevention, treatment, and recovery interventions and supports across the lifespan. (b) Increase focus and resources for prevention, treatment, and recovery services for children, youth, transitional youth, and young adults (c) Continue revitalizing the Children, Youth and Family Treatment Sub-Committee. (d) Build awareness and capacity to identify and address the changing needs of older adults due to substance use and misuse. (e) Enhance and expand capacity within the substance use workforce to better understand and address the diverse needs of higher risk and underserved populations, including those with language and cultural barriers - as recommended in the CLAS. (f) Advocate for and support increased utilization of evidence-based interventions like SBIRT in schools, workplaces, health care, and communities. (g) Advocate for and support adoption of innovative policies and promising practices and programs in substance use and misuse prevention, treatment, harm reduction, and recovery. (h) Support and advocate for increasing the state excise tax on alcoholic beverages to the median tax level nationally, and increase the portion of tax revenue allocated for prevention, treatment, harm reduction, and recovery programs.

4. **Reduce health disparities and inequities, recognize and rectify historical trauma, and address biases within systems, policies and practices.**

Objectives:

(a) Improve the effectiveness of substance use prevention, treatment, harm reduction, and recovery services in addressing the needs of higher risk and historically underserved populations.

(b) Expand scope of prevention, treatment, harm reduction, and recovery services to be inclusive of populations most impacted by social drivers of health - including socioeconomic standing, zip code, legal status, and other health disparities.

(c) Support research and identification of substance use and misuse risk and protective factors.

(d) Advocate for and support the adoption of innovative and promising practices and programs across the continuum of care that fully integrate the National CLAS Standards.