

WISCONSIN STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE



August 7, 2020
MEETING

Roger Frings
Chairperson

TONY EVERS
Governor



State of Wisconsin

VACANT
Secretary

State Council on Alcohol and Other Drug Abuse
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

OPEN MEETING NOTICE

August 7, 2020, 9:30 AM to 12:00 PM

Join Zoom Meeting

Meeting ID: 918 3471 1742

Meeting URL: <https://dhs.wi.zoom.us/j/91834711742>

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MEETING AGENDA

1. Welcome and introductions.....Roger Frings, SCAODA Chairperson
2. Approval of June 5, 2020 meeting minutes.....p. 4-8
3. Public inputSCAODA Chairperson
4. Provider Updates on Services & Challenges during COVID-19.....Council Members & Guests
5. Behavioral Health Gaps Study Report.....Abra Vigna, UW Population Health Inst.p. 9-135
6. Bureau of Prevention, Treatment and Recovery Update.....Joyce Allen, DHS.....p. 136-144
 - Executive Summary – FFY 2021 MHBG/SABG Application & Plan
7. Agenda Items for Sept. 11, 2020 Meeting.....Council Members
8. Meeting Adjournment.....Council Members

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Council's primary function is providing leadership in Wisconsin on substance use disorder (SUD) issues, advising Wisconsin state agencies on SUD prevention, treatment and recovery activities, and coordinating SUD planning and funding initiatives across state agencies. The Bureau of Prevention Treatment and Recovery within DHS staffs the Council. DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, need an interpreter or translator, or need this material in another language or format, you may request assistance to participate by contacting Mike Derr at 608-852-6403 or Michael.Derr@wisconsin.gov. See also <https://scaoda.wisconsin.gov/meetings.htm> for instructions on joining by phone or Zoom.

Tony Evers
Governor



Roger Frings
Chairperson

Sandy Hardie
Vice Chairperson

VACANT
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

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

**STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE
DRAFT MEETING MINUTES**

June 5, 2020

9:30 a.m. to 12:30 p.m.

American Family Insurance Training Center - Madison, WI

Members Present: Roger Frings, Subhadeep Barman, Christine Ullstrup, Kevin Florek, Thai Vue, Autumn Lacy, Jessica Geschke, Tina Virgil, Brian Dean, Paul Krupski (for DHS), Mary Ann Gerrard, Terry Schemenauer, Sue Shemanski, Representative Jill Billings, Natalie Aicher (for Senator Patrick Testin), Senator Janet Bewley, Jan Grebel, John Weitekamp

Members Excused: Julie Willems Van Dijk, Sandy Hardie, Michael Knetzger

Ex Officio Members Present: Ann DeGarmo, Delora Newton, Carl Hampton, Andrew Putney, Fil Clissa

Ex Officio Members Excused: Kenyon Kies, Timothy Weir, Colleen Rinken, Mark Wegner, Jennifer Wickman

Staff: Mike Derr, Joyce Allen, Teresa Steinmetz, Ryan Stachoviak, Andrea Jacobson, Allison Weber, Christine Niemuth, Dennis Radloff, Gary Roth, Amanda Lake Cismesia, Sarah Coyle, Bernestine Jeffers, Tabitha Beckwith, Beth Collier, Kenneth Ginlack, Lori Wiebold, Anne Larson, Rebecca Main, Joann Stephens, Mai Zong Vue, Kimberly Wild, Cindy Matz

Guests: Amy Anderson, Michelle Devine Giese, Harold Gates, Raeanna Johnson, Sheila Weix, Saima Chauhan, David Macmaster, Jill Gamez, Chris Wardlow, Nicole Keeler and Amy Simonsen (2 ASL interpreters), Denise Johnson, Nancy Michaud, Lynn Harrigan, Sandra Westerman, Kathy Markeland, Eugenia Sousa

Call to Order: Roger Frings called the meeting to order at 9:34 a.m.

Introductions: Members introduced themselves, via the Zoom videoconference.

Announcements: Chairperson Roger Frings welcomed everyone to the very first SCAODA Zoom meeting and expressed his appreciation for everyone's patience. He gave out reminders on using the mute and chat functions, and confirmed that the meeting was not recorded. Frings introduced the newest Council members: Jessica Geschke, Dr. Andrew Putney, Terry Schemenauer, and Carl Hampton.

Approval of December 13, 2019 meeting minutes: Tina Virgil moved to approve the minutes, seconded by Christine Ullstrup. Motion carried. (The March 13, 2020 meeting was cancelled.)

Public input: No public input was provided.

Provider updates on services & challenges during Covid-19: Thai Vue expanded on the many difficulties that the Covid-19 pandemic has caused society, and expressed frustration with the lack of resources available to treat Covid-19 for the Hmong population. Vue stated that leaders had expressed preparedness falsely, and hopes that the country is better prepared in the near future. Kevin Florek shared that Tellurian remained open since the beginning of the pandemic, explaining that these essential services are needed by community. Staff at Tellurian made efforts to comply with Centers for Disease Control (CDC) guidelines, and assured that everyone used safe health practices in many forms. Despite a notable hit to revenue, Tellurian has remained open. Senator Janet Bewley touched on the topic of access to critical services at hospitals. Specifically, Bewley spoke of Ashland Memorial Medical Center, a hospital that expected \$4 million in losses and closed down childcare treatment in view of the pandemic. In addition, the many individuals who are seeking medical services during the pandemic are also struggling with the availability of Telemedicine access, particularly regarding the usage of and access to phone minutes. Council members and guests also discussed statistics on multiple topics ranging from how Covid-19 has impacted those struggling with mental health or substance use disorders, financial losses, and the limitations and communication barriers that the deaf and hard of hearing population faces due to the usage of face masks and coverings.

Sheila Weix with the Marshfield Clinic spoke about the ability to make a seamless transition into telehealth and thanked the Department of Health Services for their rapid response. Weix expanded on the lack of inpatient services, as well the challenges of connectivity in rural areas that may provide different levels of access to Wi-Fi and telephone use, especially with the arrival of tourists. Council members discussed statistics regarding the lack of personal protection and equipment (PPE) gear, the difficulties of losing in-person services, and the sheer need for more resources altogether. One positive result has been the success and accessibility of funding and waivers permitting telehealth use. Some consumers prefer phone calls over telehealth conferencing. Jill Gamez discussed the differences of working from home with Zoom in comparison to in-person communication and how those differences impact prevention and treatment. Gamez described the challenges for adults working from home, as well as for persons who are experiencing 'virtual fatigue' from engaging online instead of in person. Although many programs have been able to transition to telehealth quickly, a common concern involved being able to successfully protect confidentiality.

Committee Reports:

Executive Committee – Roger Frings reminded members of the upcoming election for the SCAODA chairperson, vice chair-person and secretary positions. The secretary slot has been vacant since Norman Briggs left the Council. The Nomination committee consists of Sandy Hardie and Sue Shemanski. Any council members who are interested in a leadership role are encouraged to contact either Committee member or Mike Derr. Also, the September 11th meeting will not be held at American Family. Frings will look into whether his agency can host the meeting, if in-person meetings can be held by then.

Diversity Committee – Thai Vue reported that at the last Diversity Committee meeting on January 4th, committee members requested a professional facilitator to assist with planning. However, these plans have been postponed in view of the pandemic. The diversity presentation for the upcoming Fall Recovery conference has been postponed as well, and the future conference date is to be determined. The Diversity Committee is also looking for someone to serve as the co-chair.

Intervention and Treatment Committee (ITC) – Roger Frings reported a summary of the Committee discussion at its April and May meetings. The Committee brought before the Council its motion that was originally raised but tabled at the December 13, 2019 meeting.

Motion: The ITC encourages the Department of Health Services to recognize Tobacco Use Disorder (TUD) and encourages Wisconsin SUD professionals to assess and treat TUDs with evidence-based treatment practices including interventions proven to motivate individuals to try to quit. Further, ITC requests that State regulatory and credentialing bodies establish this as the standard of care in Wisconsin.

Subhadeep Barman moved to approve and Thai Vue seconded. All Council members approved motion except Natalie Aicher, who abstained on behalf of Senator Testin. Motion carried.

Planning and Funding Committee – Christine Ullstrup mentioned that the Fall Mental Health and Substance Use Recovery Conference has been switched to a remote conference for three days – Oct. 28-30th. She and DHS just learned that the Committee’s proposed open forum and advocacy session was accepted, so the Council’s listening session will occur during the main portion of the conference. The Committee brought a motion before the Council to consider.

Motion: SCAODA encourages Department of Health Services to consider policies and practices ensuring that existing non-profit grant recipients who receive a new grant award continue receiving payments in the new year during the period when the new contract is not yet fully executed.

Christine Ullstrup moved for the council to approve motion, and Senator Janet Bewley seconded. Teresa Steinmetz, Bureau of Prevention Treatment and Recovery Deputy Director, expanded on some of DHS’s history with contracting and its current payment structure in relation to the motion. Several years ago, advance payments to non-profit grantees was discontinued department-wide to align with Medicaid rules prohibiting the use of advance payments. Also, department-wide changes to the contracting process and the associated learning curve has contributed to delays. Furthermore, the number of contracts administered annually by the Bureau has dramatically increased (now more than 700) due to the launching of several new grant programs, without corresponding increases in contract specialists. Last winter, the Bureau hired a new full-time contract specialist, Cindy Matz. Having an additional specialist has noticeably reduced time for processing contracts, cutting the overtime lapse by half. Thirteen Council members Grebel, Lacy, Barman, Dean, Schemenauer, Florek, Rep. Billings, Weitekamp, Vue, Shemanski, Gerrard, Ullstrup and Sen. Bewley approved the motion. One member (Tina Virgil) opposed the motion. Four members -- Natalie Aicher (for Sen. Testin), Paul Krupski (for Julie Willems Van Dijk), Jessica Geschke and Roger Frings abstained. Motion approved.

Prevention Committee – Chris Wardlow provided a committee update and expanded on the Small Talks campaign, which launched during the spring. The Committee brought two motions for Council consideration.

Motion #1: SCAODA will write a letter requesting the Governor and Legislature to clarify and/or revise for public health and health and human service agencies the statutes regarding the prescribing, dispensing and delivery of an opioid antagonist. Furthermore, the Prevention Committee asks SCAODA request clarification of the intent of the Governor and Legislature to include public organizations under the Good Samaritan Law (Wis. Stat. §450.11 par. c).

Frings moved to approve motion and Barman seconded. After a brief discussion, the vote was taken. All present Council members approved the motion, except Natalie Aicher (for Sen. Testin), who abstained. Motion approved.

Motion #2: Form an alcohol prevention ad hoc workgroup that would develop a recommendation report and a public health response to issues related to alcohol use.

Frings moved to approve the motion and Thai Vue seconded. After no further discussion took place a vote ensued on the motion. All present Council members approved the motion. Motion approved. Thai Vue encouraged the prevention committee to include a representative from a non-traditional or under-represented group on the new ad hoc workgroup.

Presentations:

Nancy Michaud provided an update on the FFY 2020 Synar report. In 2019, the state's violation rate was down to 5.5%. She reminded Council members of the initial Synar amendment limiting tobacco sales at the legal age of 18, and the requirement that states maintain a violation rate under 20%. Recent federal legislation raised the legal age limit to 21. Michaud also discussed the tentative plan to continue compliance checks including random and unannounced with retail distributors, as well as outreach details for businesses and schools, and the usage of flavored and non-flavored tobacco products by youth. Given Covid-19, it may be unfeasible to conduct in-person compliance checks, and DHS will seek guidance from SAMHSA on variances to requirements.

Paul Krupski spoke on behalf of Julie Willems Van Dijk to thank everyone for their support and ongoing work with the State Emergency Operations Response team to provide COVID-19 support. Regarding the Hub & Spoke Initiative, Krupski stated that more information will be shared next week with stakeholders. The DHS Secretary's Office will provide a COVID-19 overview on moving forward, staying safe, containing, testing, isolating those that are ill, and boxing in the virus as best as possible, plus vigilance and prep for a potential surge this fall.

Agency reports:

Governor's Office – no report.

Department of Health Services – no report.

Department of Safety & Professional Services – no report.

Department of Revenue – no report.

Department of Public Instruction - no report.

Department of Veterans Affairs - no report.

Department of Justice - Tina Virgil shared that services, resources and funds that are available specifically to tribes on effective Covid-19 services. The intoximeter pilot program was supposed to end in 2016, but was extended and as of 2019 the final report was submitted. The program itself is no longer available. The spring Drug Take Back Day was cancelled, however, drug take back boxes are available to people in their communities. More information is available on the agency's website. She will share the Treatment Alternatives and Diversion (TAD) Program 2020 report with the Council.

Bureau of Prevention, Treatment and Recovery Update: Joyce Allen provided a general BPTR update, explaining that trainings and conferences that have changed to virtual meetings have been listed in the booklet on pages 109-111 of the booklet. Allen also expanded on the emergency order in relation to Covid-19, the overview of responses and activities and some staff transitions. Bernestine Jeffers and Cecie Culp have moved on to new positions, and hired Andrea Jacobson as the Substance Abuse Section Chief, and Kenneth Ginlack as the AODA treatment coordinator. Allen also shared that she will be retiring from her position in early August, and that Teresa Steinmetz will meanwhile update the Council of bureau activities. Additionally, Amanda Lake Cismesia provided a brief update on the DHS 75 rulemaking project, explaining that the rule is back from Office of Legal Counsel with comments and recommended edits. The next formal steps will involve public posting and a comment period. Roger Frings thanks Allen for all of her work and many years of service.

Report from Wisconsin Council on Mental Health: Mike Derr shared that the Mental Health Council's March meeting was cancelled, then met in May. As the council continues to work on budget priorities, more information on mental health priorities will come with future meetings.

Agenda Items for Future Meetings: Roger Frings shared potential details for the following future meetings: A shorter Council meeting in July or early August focusing on the Behavioral Health System Gaps Analysis findings; the September Council, if in person, could be held at the Office of Commissioner of Insurance; a future Council meeting should be held out of Madison in a rural setting. Other upcoming meeting topics included recovery housing presentations by Christine Ullstrup and Michelle Devine Giese, the Wisconsin Voices for Recovery and the Safe Harbor programs, and the September meeting election of the Council chair, vice chair and secretary positions.

Meeting Adjournment: Roger thanks all in attendance and wished everyone well, to stay healthy, to be kind, and to take care until the next meeting. Frings moved to adjourn, Christine Ullstrup seconded the motion. All in favor. None opposed. Meeting adjourned at 12:42p.m.

2019 WISCONSIN BEHAVIORAL HEALTH SYSTEM GAPS REPORT

Results of Key Informant Interviews, Surveys, and Consumer Focus Groups



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**



University of Wisconsin
Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

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The 2019 Wisconsin Behavioral Health System Gaps Report was jointly requested by the Wisconsin Governor’s Council on Mental Health and the State of Wisconsin’s Department of Health Services. This report was funded by the State of Wisconsin’s Department of Health Services, Division of Care and Treatment Services, Bureau of Prevention Treatment and Recovery.

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Companion Technical Appendices:

This report is accompanied by a separate document of Technical Appendices including details on the study methodology, survey and interview instruments, and types of study participants. Also included in an appendix is a more detailed report of the findings from the consumer focus groups.

Ubuntu Research and Evaluation was contracted to perform the data collection, organizing, and facilitating of the consumer focus groups. Ubuntu also analyzed the focus group data and their full report on the findings is found in Technical Appendix F. The main findings from the focus groups are integrated with the survey and interview findings throughout this full report. As a Black Women-owned and -operated evaluation group, Ubuntu was subcontracted to distribute resources devoted to this work more equitably and to promote focus group participant comfort in speaking candidly. Ubuntu uses liberation and beloved community frameworks to evaluate, facilitate, and strategize with individuals, organizations and communities. For more detail, see <https://www.ubunturesearch.com/>.

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Executive Summary

In the fall of 2018 the Bureau of Prevention, Treatment, and Recovery in the Wisconsin Department of Health Services funded a Behavioral Health Gaps Study to conduct a multi-method assessment of the gaps and needs in the behavioral health service system for individuals with mental health and substance use needs. While previous assessments relied on existing data from state and federal data systems, the Behavioral Health Gaps Study collected the knowledge and experience of stakeholders to assess the gaps and needs. Another unique feature of the study is its assessment of stakeholder priorities and recommendations to address the needs and gaps. The assessment consists of interviews, surveys, and focus groups with a wide range of stakeholder groups with experience in the behavioral health system including public and private providers, advocates, and consumers. Administrators and direct providers with experience in the youth and adult service systems participated from both urban and rural areas. Consumers from a variety of historically underserved populations provide their perspectives to the study as well. This report summarizes the behavioral health system needs and gaps based on these perspectives.

Overall Key Gaps and Barriers

A primary component of the study was the identification of the gaps and barriers in the behavioral health service system and their importance. Stakeholders were asked about gaps in the service array, the accessibility of services, the quality of services, and the preparedness of the workforce. Opportunities were provided to describe gaps and barriers in both the mental health and substance use service systems and to identify specific populations that may be more adversely affected by the gaps and barriers.

The key gaps in behavioral health services highlighted across data sources included: shortages in **child and geriatric psychiatrists**; shortages in mental health **inpatient beds** and **residential facilities** for treating substance use; the inadequacies of the medical transportation system; a need for improving **crisis stabilization services** in the community that focus on reducing contact with police officers; shortages in **medication-assisted treatment** providers and clinics; long **waitlists** across the service array; shortages in competent **translation services**; and the need to provide **wraparound services**, particularly for consumers with families.

Across the service array, without looking at region or whether the services are for youth or adults, survey respondents listed the most frequent barriers to receiving treatment in the following order: 1) cost or insurance rules, 2) geography, 3) cultural mismatch between service and clientele, 4) workforce or facility shortage; and 5) other. Comparing relative frequency across and within each service array suggests that according to respondents of the survey, payment /insurance barriers and geographic barriers are most frequent among inpatient and residential services. Among SU services, workforce/facility shortages are suggested to be equally most frequent for both detox and inpatient/residential services, whereas a workforce/facility shortage was noted as most frequent in the MH service array among outpatient services. For both MH and SU services, cultural barriers were identified as most frequent in outpatient services. Stigma in the form of worldviews that imbue shame onto behavioral health needs and contexts that

discriminate against consumers that have sought behavioral health services were noted as two notable barriers to behavioral health services across the arrays. It was also highlighted that stigma regarding both MH and SU needs may be particularly deep rooted in rural areas.

Perhaps of greatest concern for health equity is the perception that, due to the lack of available and accessible services, some consumers may only be able to receive care after becoming involved with the criminal justice system. This appears to be disproportionately true for youth of color. Additionally, the lack of effective coordination with BH services for consumers taken into custody and during transitioning out of incarceration were raised as key areas for the BH system to focus on addressing health inequities.

Workforce Conditions Associated with Gaps

Across the array, the top three workforce conditions perceived to be contributing to gaps in services included too few workers with expertise for specialized populations; too few entering the field in total and the strong perception that the root cause of the workforce shortages is the low wages relative to the private sector. These low wages were unanimously attributed to insufficient increases in the Medicaid reimbursement rate over the last two decades. In the survey, **“salary too low”** and **“too few entering the field”** tied for most acute workforce conditions in SU services, whereas **“too few prepared for specialized populations,”** and **“too few entering the field”** tied as most acute among MH services, reflecting the patterns expanded upon below.

Specific Populations Falling Through the Gaps

Consumers with co-occurring MH and SU diagnoses, young people up to the age of 25, the elderly and those multiply marginalized by falling into one of the aforementioned groups *in addition to* being a racial minority, sexual or gender minority, facing homelessness or an undocumented resident were most frequently identified as falling through the gaps in the system. For individuals with co-occurring needs, the lack of insurance coverage to address both issues simultaneously was a key theme attributed to underserving this population, for the both children and the elderly the lack of an appropriately trained workforce and the lack of community-based services were key themes. Consumers with either MH or SU needs and a cognitive/intellectual disability, veterans, criminal justice-system involved, the deaf and hard of hearing community, those with chronic illnesses and the uninsured were other populations highlighted as particularly underserved by the current BH system.

Mental Health Gaps and Barriers

In the interviews, **psychiatrists and psychiatric prescribers** were the most common workforce gap identified in mental health. **Inpatient and residential mental health services** were identified as most challenging to

access because of both insurance limitations/cost and physical distance to said facilities in the current state of the system.

Rural areas struggle with **transportation** barriers and **hiring** challenges due to better wages in the private system and across state lines, and that medical transportation is currently ineffective in closing geographic gaps in facilities. In urban areas, long **waitlists** and lack of sufficient **workforce diversity were highlighted as key challenges**. Across the state, there were also serious concerns about individuals with mental health needs ending up in the **criminal justice system** and not getting appropriate care facilitative of recovery.

Challenges with the **crisis service system** were frequently discussed, the perception that consumers are frequently deemed ineligible for treatment until their condition has worsened, consumer costs associated with services, punitive no-show policies and general challenges in navigating the system among both providers struggling to interpret codes and consumers unaware of available MH services were all identified as significant barriers to care in the MH system. Although knowledge of evidence-based practices was perceived as high, fidelity to their effective application was identified as low due to workforce shortages.

Almost half of the respondents to the survey highlighted the need to **increase access** to mental health services as a priority area including suggestions to develop a regional model such as the hub and spoke model utilized in SU. Close to one-third of respondents highlighted a need to both **develop the workforce** and **focus on funding** in order to reduce operating costs and reduce turnover for individual behavioral health organizations. One fifth felt that the **service array** needed to be altered by increasing case management services, offering respite to families, addressing the root causes of MH challenges via improving the social determinants of health such as safe and affordable housing and childcare, and by improving crisis services with a reduced reliance upon police as a resource.

Gaps and Barriers Specific to Youth and Elderly MH Services

Broadly, interviewees felt that youth faced **similar but wider gaps** in mental health services. However, there were some priorities identified that are specific to youth. Schools face administrative barriers to housing **outpatient mental health services**, even though they are now billable through Medicaid. **Child and adolescent psychiatrists and psychologists** were cited as a critical workforce shortage in Wisconsin, more acute than psychiatrists generally. There were also calls for increasing access to **youth crisis diversion and intervention**, and **residential options** to prevent youth entry into the juvenile justice system, child welfare, or out-of-state treatment. Finally, a key concern with the elderly population is that in the absence of a workforce knowledgeable in navigating the unique needs of an aging population combined with the absence of community-based options, the elderly are unnecessarily placed in more restrictive environments inappropriate to their needs and therefore not conducive to recovery.

Substance Use Gaps and Barriers

Interviewees and respondents called for increased access to **medication-assisted treatment (MAT)**, especially in the northern half of the state and in more rural areas. There was also an identified need for

more (and better) **crisis services**, particularly detox, and **sober housing** options. As with mental health, rural areas struggle with **transportation** barriers and **hiring** challenges. In urban areas, there was a focus on long **waitlists** and lack of sufficient **workforce diversity**. There were also concerns about people **detoxing in jails and prisons** without adequate care, leading to overdoses upon release or cycles of incarceration. Although stigma was listed as a barrier across the system, it was described as a stronger barrier to substance use services with respondents indicating that even within behavioral health services, there is common stigma regarding the use of MAT and that mental health providers are reluctant to treat individuals with substance use needs.

Substance use recommendations centered on securing **better reimbursement rates** for substance use services and **expanding the list of credentials** eligible for reimbursement, ensuring the training provided to this expanded list of credentials includes sufficient training in SU, and working with primary care providers to provide medication-assisted treatment. There was also a repeated concern that **more oversight or free training** is needed to ensure current providers with mental health backgrounds that are approved to treat SU are adequately prepared to do so. **Peer specialists** were listed as an underutilized resource that should be better incorporated into the behavioral health system. Finally, addressing the **social determinants of health** such as housing and employment, particularly during re-entry from the correctional system or transition from the youth to adult service systems, was highlighted as an important precursor to successful recovery from addiction. This included changing the income limitations for Medicaid in order to sustain treatment beyond initial reintegration into the workforce when occasional relapses are common.

Gaps and Barriers Specific to Youth and Elderly SU Services

Services for adolescents with SU needs were identified as lacking with residential treatment options identified as non-existent. Offering services in schools and educating young people about SU and how to access treatment via the BH system were two recommendations identified to address gaps and barriers specific to youth. For the elderly, the key concern was that their SU needs are often overlooked and that when they are identified, the knowledge needed to coordinate SU services with other aging needs is highly specialized and generally lacking in the current workforce population.

Health Inequities and the Behavioral Health System

Marginalized social groups experience disproportionate risk of behavioral health challenges as a result of coping with historical and ongoing systematic reduction of community resources, incarceration, displacement, social alienation, and state violence. Access to needed care among these groups is also constrained by marginalizing policies and practices currently in place within the behavioral health system.

Results from this evaluation indicate a range of health inequities that both affect the behavioral health system and are sometimes created by it. For example, the lack of culturally diverse behavioral health and other community providers can directly lead to reduced access to care for culturally diverse consumers. Legacies of ineffective or inappropriate care for people of color was described as discouraging care-seeking

in the first place. When symptoms escalate in the absence of adequate services, the abiding concern is that the behavior of consumers of color is more likely to be deemed criminal, thus contributing to the inequities seen in disproportionate incarceration rates of Wisconsin residents of color.

Difficulties in coordinating services with sovereign nations were noted as a prominent challenge potentially attributing to health inequities documented in tribal nations. Similarly, the absence of a living wage, or workforce protections for those without salaried positions combined with the strain of caregiving for either aging adults or young children was highlighted as compounding the impacts of the various barriers and gaps described in this report.

Historical, community-wide traumas and ongoing/emergent personal experiences of institutional mistreatment contribute to some communities' **lack of trust in behavioral health systems**. When individuals from these groups do seek help, services may not be equipped to adequately meet their needs: treatment approaches lack **cultural appropriateness**; they may face **implicit bias** in intake, eligibility, and treatment; and **translation services may not be available or adequate**. On the system side, behavioral health organizations **struggle to hire diverse and multilingual providers** in a context of widespread workforce shortages. Statewide attention to these health inequities, and the policies, practices, and conditions that produce them, is a critical step forward.

Stakeholders' Prioritized Recommendations

Priorities often reflected the experience of the group responding. For example, many interviewees were State staff and their priorities centered on improving funding, addressing the statutes that govern care and licensure requirements, and addressing inequities in the diversity of providers and services. Conversely, survey respondents, who were predominantly composed of outpatient providers, administrators and advocates, focused more on improving access to the system. Finally, and most importantly, priorities suggested by the focus group participants reflected their perspectives as hypermarginalized consumers and centered on addressing the mechanisms of marginalization in the system.

Nevertheless, **the most consistent recommendation was to increase reimbursement rates and the list of reimbursable activities**. A close second was the recommendation to combine mental health and substance use services while requiring all behavioral health providers to be dually-credentialed, and third, to adopt a regionalized hub and spoke model in an effort to combine resources and promote geographic coordination. Shy of these system-wide changes were recommendations to address gaps in services by increasing the array of Medicaid-reimbursable behavioral health services (such as peer specialist services) and providing startup grants for new providers seeking to relocate in the northwest region of the state. Outside of financial and system coordination concerns the priority areas that emerged included addressing stigma about behavioral health and spreading awareness of what services are available as well as how to access them, particularly among youth in middle school and high school.

As noted by the World Health Organization, “a characteristic common to groups that experience health inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is a lack of political, social or economic power. Thus, they instruct: “to be effective and sustainable, interventions that aim to redress inequities must typically go beyond remedying a particular health inequality and also help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships (WHO, 2020).” As such, this analysis prioritizes recommendations that address these root causes of health inequities and invests in the leadership of marginalized groups.

Most Urgent System-wide Priorities: Addressing Health Inequities

Priority recommendations to help address the inequities in the behavioral health system include: **1) prioritize recruiting and offering incentives for providers of color and bilingual providers** to join the profession including using grants and reserving funds for subsidizing educational costs for psychiatrists of color or funds to support translation services for deaf and hard of hearing providers in training; **2) Build partnerships with historically marginalized communities by including representatives in decision-making bodies** regarding system and service changes and to employ community members to serve as system navigators; **3) Increase provider capacity for a trauma-informed and healing-centered approach** for working with historically marginalized populations and provider oversight to address implicit bias; **4) Invest in crisis diversion alternatives that avoid criminal justice engagement** and advocate for collectively addressing the social determinants of health such as housing, childcare and worker protections as a fundamental driver of mental health or substance use disorders; and **5) shift away from a county-levy funding system to a more regional approach** in order to dampen the ongoing inequities put into place by segregation and redlining policies.

Most Urgent System-wide Priorities: General

The vast majority of priorities identified by survey respondents centered on **improving access to the system, particularly for consumers with dual diagnoses, consumers aged 25 and under, the elderly and those facing homelessness**. Although listed in the surveys as the least urgent area for prioritization, in actuality, combining the administrative rule for SU and MH services is a necessary step in improving access for consumers with dual diagnoses.

The second most urgent solution areas highlighted were, with equal frequency, **increasing funding and developing the workforce**. The third and fourth most urgent recommendations were to **change the approach** to behavioral health treatment and to **improve internal coordination of services**. Stakeholder recommendations within each of these five major themes are described below. Note that although focus on funding emerged as third most urgent, changes to funding are likely necessary to pursue any of the recommendations identified in the two more urgent priority areas.

#1 Increase Accessibility

Recommendations of this type addressed areas such as awareness of how to access services, location of services, reduction of waitlists, rule changes to increase providers and/or consumers in the system, increase technical assistance from and increase the speed of provider approval within the State Department of Human Services; and increase the variety of treatment and wraparound services for consumers in transition from restrictive placements.

Hire community-based system navigators from marginalized communities to perform outreach and referral services in order to increase access to the behavioral health system among underserved communities.

Reduce geographic barriers by providing more services within the community. While increasing transportation options was mentioned, the more frequent recommendation was to increase the availability of services where people live such as in-home therapy programs, drop-in community-based wellness and recovery centers, telehealth, and school-based services. Transition to a regional, hub and spoke model was also a common suggestion for addressing geography and facility shortages.

Provide access points to services that are independent to the criminal justice system and child protective services. Although many county services are co-located in order to share overhead costs, given that the pursuit of behavioral health services used by the legal system as a sign that someone is less competent of a parent or trustworthy of a parent, providing satellite locations was highlighted as an important solution to dampening the effect of institutionalized stigma upon the willingness to pursue services.

Prioritize crisis response alternatives that avoid engaging the police and criminal justice system. Noted as serving as a mechanism of inequity, a source of emergent trauma, and a deterrent to health seeking behavior from communities facing disproportionate contact with law enforcement, identifying solutions to reduce reliance upon police contact would increase system accessibility.

Increase intensive outpatient services for consumers in transition. A common concern was the absence of the coordination of intensive services for consumers transitioning back into the community from incarceration or restrictive services such as hospitalization. For consumers with substance use needs, for example, the use of sober houses and halfway houses were identified as under-utilized.

Increase availability of youth full-day treatment and overnight respite for families. Full rather than half-day treatment better accommodates working parents' schedules and respite helps preserve family relationships when parents have the opportunity for a break during intense or prolonged periods of stress.

Offer more specialized substance use support groups. Access to support groups addressing specific rather than all substance use issues as well as support groups offered in Spanish and other languages would increase their effectiveness.

Reduce wait lists by broadening the array of professionals allowed to be reimbursed and the number of provider services that qualify for services. Expanding the allowable role of professionals such as peer specialists, marriage and family therapists, and licensed social workers can help address workforce shortages and thereby reduce time spent waiting for treatment. Additionally, expanding the list of re-

#2 Develop the Workforce

Recommendations of this type addressed areas such as workforce shortages, education costs, dual certification requirements, recruitment into specific positions, working with diverse populations, and the use of evidence-based practices.

Change licensing policies to enable more substance use providers. License certification can be complicated and thus discouraging for some potential substance use providers. In addition, Medicaid licensure requirements in order for substance use services to be reimbursed is viewed by some to be unduly burdensome.

Improve provider capacity to work with diverse, specialized populations contended with the stressors associated with social marginalization. In addition to prioritizing the recruitment and hiring directly from these communities, enhancements can be made to higher-education training programs and accountability measures can be built into ongoing licensure requirements in order to improve cultural humility, knowledge and care for marginalized consumers. Priority populations include in no particular order: the deaf and hard of hearing community, children, the elderly, individuals with co-occurring needs, and consumers that do not speak English.

Train providers in a variety of sectors in trauma-informed care. Providers inside and outside the behavioral health system including teachers, childcare providers, police, and social workers need continued education on the effects of historical trauma on an individual's behavioral health condition.

Address the provider shortage in rural Wisconsin, especially in psychiatry. Suggestions for doing so include pointed recruitment strategies, offering tuition remission, providing internships in rural areas, offering grants for startup costs, and student loan forgiveness programs.

#3 Improve Funding

Recommendations of this type addressed areas such as Medicaid reimbursement rates, public and private insurance coverage, parity, and overall funding levels in the behavioral health field.

Increase the Medicaid reimbursement rate. The majority of interviewees directly called for increasing the rate of Medicaid reimbursement for behavioral health services which they believe can reduce service gaps, improve workforce recruitment and retention, and encourage innovative approaches to care.

Expand Medicaid/Medicare coverage. Examples included expanding Medicaid coverage to services such as peer specialist outpatient services, remote psychiatric consultation to primary care, and holistic care like yoga and acupuncture. Also mentioned was expanding Medicare for the provision of SU services to the elderly. In addition, the Medicaid reimbursement rate for satellite locations is lower than the rate for the hub agency location which is restricting access to services in the satellite agency locations.

Identify new sources of state revenue for behavioral health services. Even for some consumers with insurance, high deductibles and copays can be cost-prohibitive. Contributing more state revenue in targeted areas could help including earmarking taxes on alcohol sales to provide no-cost inpatient treatment options. Another example offered was using fines for operating while intoxicated offenses for treatment of drunk drivers, even if they have insurance, which is currently restricted. Alternately, it was suggested that the cost-savings of preventing incarceration with adequate treatment will pay for themselves given the costs of incarceration.

Increase affordability for consumers. Some recommendations here ranged from increasing the range of treatments that are reimbursable, to free-of-charge. A very common barrier was the co-pay for treatment. Too many consumers who could truly benefit from treatment cannot afford to pursue it.

Enforce parity in coverage between behavioral health and physical health as well as between base and satellite locations for services. Some interviewees suggested increasing state enforcement of parity in coverage between behavioral health and physical health is necessary. For example, one recommendation was to increase resources for the Office of the Commissioner of Insurance to ensure staff can follow through comprehensively on parity investigations. Others noted that in the existing organizations offering a hub-and-spoke model for access often fail to reimburse spoke/satellite locations with parity to hub/base locations.

#4 Supplement the Approach to Clinical Treatment

Recommendations of this type addressed areas such as a recovery vs. treatment approach, holistic conceptualizations of behavioral health care, the role of stigma, and the inclusion of non-traditional providers into the behavioral health service provision process.

Intensify efforts to build a recovery-oriented system. An example cited was expanding recovery-focused staff to be at every contact point in the behavioral health system including administrative positions as well as direct service positions.

Focus on preventative services. Many respondents would like to see a shift in resources and attention toward prevention and early intervention services to identify behavioral health needs earlier and prevent expensive, emergency care later. Respondents also asked for more data collection and analysis of preventative activities to demonstrate the long-term cost-saving impacts and justify the investment.

Counter the stigma that delays help-seeking. The sooner the view that behavioral health concerns are a sign of defect or criminality is eliminated, the sooner people will seek support thereby potentially reducing the strain on intensive behavioral health resources for public and private service providers.

Incorporate efforts to address the social determinants of health for consumers. Social determinants such as physical health, income, and community connections can have a significant impact on behavioral health. Increased efforts to provide adequate housing for consumers was mentioned frequently to provide stability during treatment.

Coordinate with schools to improve awareness and access. A large number of respondents described the need to more actively engage with schools including the use of a full-time staff member specialized in behavioral health rather than the part-time social worker model used in some schools. The need to educate school staff about warning signs of early or acute symptoms was also described.

Create opportunities for greater community representation in decision-making bodies executing changes to the BH system. Bringing marginalized populations into the decision-making process is a best practice in the work to advance health equity. This includes approaching consumers with the dignity they deserve and re-organizing decision-making bodies and processes so that the voices of those most impacted by the gaps in the system are given greater weight and their solutions a higher priority.

#5 Improve System Coordination

Recommendations of this type addressed areas such as regulations that govern mental health and substance use services, regional or statewide system coordination, use of data reporting systems, coordination with primary care providers, and technical assistance for other providers outside the behavioral health system.

Revise and combine statutes that govern behavioral health care. Interviewees commonly called for an update to the statutes and administrative codes that regulate behavioral health services. The effective integration of mental health and substance use services is sometimes inhibited by old statutes and codes that do not incorporate the best practices that are available today.

Integrate behavioral health training into all health system positions. There are also key opportunities to improve consumer access by strategically connecting behavioral health to other systems. Significant support exists for increasing the capacity of primary care providers to initiate conversations with patients about mental health and substance use, including co-locating behavioral health services with primary care services to reduce transportation barriers and promote follow-through on referrals.

Move to a regional model for funding and services. A common suggestion was to move toward regionalizing funding structures, unifying behavioral health data systems, strengthening regional behavioral health coordination and leadership, or investing in hub-and-spoke or telehealth models.

Hire community-based system navigators from marginalized communities to perform outreach and referral services in order to increase access to the behavioral health system among underserved communities.

Background

Every two years, the Bureau of Prevention Treatment and Recovery within the Division of Care and Treatment Services (DCTS) in the Department of Health Services (DHS) writes a Behavioral Health Needs Assessment Report to inform its distribution of federal Block Grant and state funds to support and improve the public behavioral health service system. In the fall of 2018, the DCTS authorized an expanded assessment of Wisconsin's behavioral health service system addressing mental health and substance use disorders called the Behavioral Health Gaps Study. While the traditional Needs Assessment relied on existing data from state and federal data systems and surveys, the Behavioral Health Gaps Study seeks the knowledge and experience of stakeholders in Wisconsin's behavioral health system. Another unique feature of the study is its assessment of priorities and recommendations for action from stakeholders. It is a one-time special study conducted by the University of Wisconsin Population Health Institute on behalf of the DCTS.

The following evaluation questions were developed in collaboration with DHS staff and guided the development of the methodology of this project:

- What are the major systems-level gaps in the availability of behavioral health services?
- What are the barriers to accessing services?
- Are there areas/regions wherein the gaps are particularly pronounced?
- Are there populations that are particularly underserved by the system?
- What gaps in the workforce impact its ability to meet the needs of the population?
- How and in what ways does implicit bias play a role in producing these gaps?
- What are the stakeholders' recommendations for improving the behavioral health service system?

Method

An advisory team internal to the Division of Care and Treatment Services (DCTS) was assembled in January of 2019 to provide oversight of the project. This diverse team consisted of DCTS management, clinical staff, program planners, evaluators, a Special Populations Coordinator, and a Consumer Affairs Coordinator. Following a brief literature review of similar analyses of other statewide behavioral health systems, key informant interview questions and the online survey instrument were developed concurrently through an iterative process with the internal advisory group, and via piloting of the instruments by DCTS staff external to the advisory group (See Technical Appendix A for details on the data sources used for the gaps analysis and Technical Appendix B for a copy of the semi-structured interview questions). The scope of this gaps analysis was limited to assessing gaps in behavioral health (BH) services outside of the forensic system.

Data Sources: Stakeholders Represented in this Gaps Analysis

Three methods were used to gather input from different individuals with different relationships to the behavioral health service system in Wisconsin. Face-to-face interviews, web-based surveys, and focus groups were all used to gather a broad set of input in a complimentary manner. Each methodology was used to involve slightly different groups of individuals. Data from all three sources were compared and triangulated in order to provide clarity where there is consensus about the gaps and where the different data sources disagree and demonstrate the influence of different perspectives. In all, this mixed-method approach allowed a broad set of perspectives to be included in the report.

Key informant interviews. With the guidance of the internal advisory team, key stakeholders were identified for in-depth interviews. Interviewees were selected based on their broad experience and systems-level knowledge, and included State DHS staff, County BH directors and program managers, advocacy agency directors, and directors/CEO's of private BH service agencies. Additionally, a balance of perspectives was sought between urban and rural areas, youth and adult services, public and private behavioral health services, and statewide and local concerns. In all, 39 individuals completed interviews.

Respondents were first asked to share their perspectives on gaps in the Wisconsin behavioral health system, in terms of availability, accessibility, and adequacy of services. They were also asked to identify particular areas or populations for whom the gaps are most pronounced. After reflecting on perceived gaps in the systems, respondents were asked to identify their hypotheses regarding the root causes of these gaps, their consequences, and potential remedies.

Online survey of behavioral health system stakeholders. The provider survey was designed to obtain input from a larger number and wider range of stakeholders than the key informant interviews. While the interviews included mostly State government staff and local administrators and managers, emphasis was given to including direct service providers in the survey process. The survey was distributed to service providers including county behavioral health providers, state mental health institutes, private behavioral health providers, and behavioral health professional associations. In addition to direct providers, state behavioral health agencies and other state agencies that oversee behavioral health services for special populations (i.e. Department of Corrections, Department of Children and Families) were invited to respond. Peer specialists and advocacy organizations were also invited to respond.

After indicating if they wish to respond about the MH service system, the SU service system, or both, respondents described the barriers to accessing services that consumers face (e.g. geographic barriers, cost, etc.). They identified barriers separately for four primary service array components. For the MH system, for example, the service components were inpatient, residential, crisis, and outpatient. In later sections of the survey respondents were asked to reflect on which populations were most vulnerable to falling through gaps in services and to describe their recommendations and top priorities for improvement of the system. Finally, respondents were asked to share their demographic characteristics. See Technical Appendix E for a copy of the survey.

Although 1,362 individuals started the survey, as is typical with surveys, there was considerable attrition with the numbers completing each question continuously declining throughout. As such, the numbers of respondents to each question fluctuates considerably. In total 1062 surveys regarding MH services were begun and 841 completed in full. Conversely, in total 754 surveys regarding SUD services were begun and 574 completed in full.

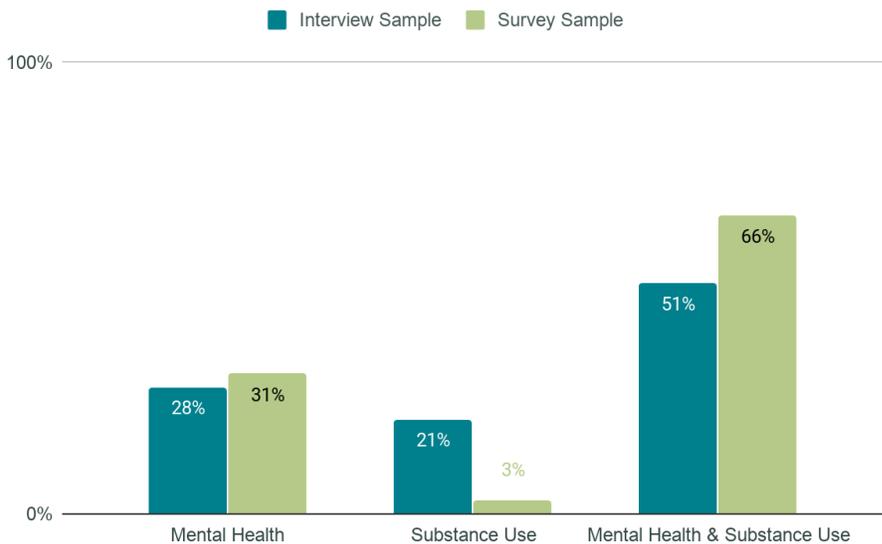
Consumer focus groups with marginalized populations. Although some consumers completed the survey, focus groups were specifically used to ensure consumer input on the behavioral health system. While the interviews and surveys included mostly structured questions that created a very structured input process, focus groups were designed to give consumers more flexibility to share their personal perspectives in their own way. A second objective of the focus groups was to provide a forum for historically marginalized populations to be heard. Between May and September of 2019, 71 consumers participated in 9 focus groups facilitated by a Black women-owned and run Evaluation organization subcontracted to both distribute resources devoted to this work more equitably and to support focus group participant comfort in speaking candidly. Input from twelve additional hypermarginalized consumers was obtained via alternative protocols deemed more appropriate. For example, in lieu of focus groups that relied upon interpreters, a survey was used to obtain input from individuals who are deaf or hard of hearing (n= 6). Additionally, a workshop format was utilized to collect input from consumers made up of Chin, Burmese and Rohingya refugees (n=6).

Focus groups lasted between 30 to 90 minutes and were held at sites across the state that were convenient and comfortable for participants. At the beginning of each focus group, the facilitator welcomed people into the space, explained the purpose of the focus group, answered any questions and obtained written and verbal consent. Each focus group began with an activity that allowed participants to get comfortable before the focus group discussions. Each verbal focus group was audio-recorded and subsequently transcribed. The evaluation team is bound by a non-disclosure agreement to fulfill participants' reasonable expectation of confidentiality. The transcriptions were then coded and analyzed.

Individual Perspectives Represented in the Data

In the survey and interviews, participants were asked to identify their *current* role in the BH system; what parts of the system they are familiar with (i.e. mental health or substance use services, or both); the length of time they have been in their current role; and the length of time they have been affiliated with the behavioral health system in total. This latter question allows for an understanding of professional movement within, or adjacent to, the system. Finally, demographic characteristics were collected because race, gender, and sexual orientation can affect how people perceive the world—and what they don't perceive. The goal of these questions was to help get a better sense of the different perspectives that the survey and interview results reflect.

Figure 1: Perspectives on the Behavioral Health System by Service Area



Experience working in the mental health and substance use service systems. Among both the key informants interviewed and survey respondents, over half had experiences with both mental health (MH) and substance use (SU) services, and just under half indicated the ability to speak to services for both youth and adults (See Figure 1.). As is reflective of the composition

of the workforce, the smallest subgroup in our survey sample were individuals that only felt prepared to reflect on the array of services for treating SUD (n=41). Most focus groups participants reported utilizing MH services. While the use of SU services did not emerge organically during the discussion portion of the focus groups, several participants did refer to SU services during their warm-up activities.

Familiarity with the BH system. Most of the individuals surveyed and interviewed drew on a long history of work in the field of behavioral health. Over half of the survey respondents reported that they had been in the field for over ten years 57% (n=632) and over three-fourths of the key informants interviewed reported 10+ years of experience with the system (n=29). In contrast, only 12% of survey respondents (n=130) and 6% of key informants (n=2) had been working in behavioral health for less than a year (Figure 2). Although the stakeholders that contributed to this analysis were largely tenured in the field, both data sources were composed of a fairly evenly distributed experience in one's current role in the behavioral health system (Figure 3).

Figure 2: Lifetime Years of Professional Experience in the BH System

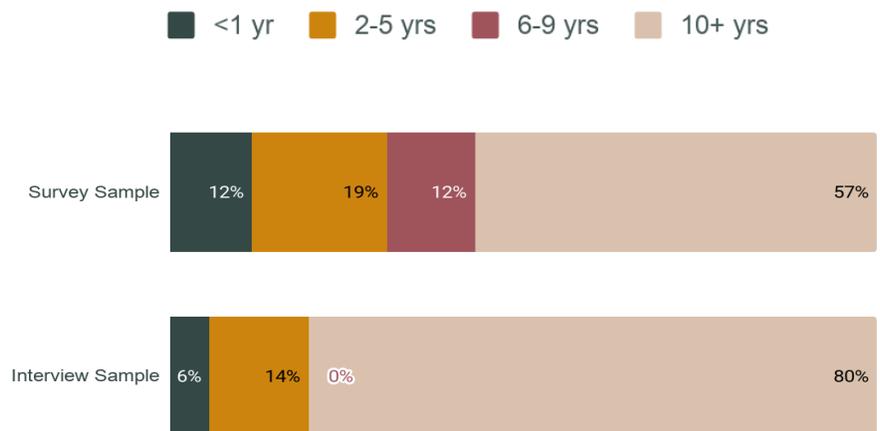
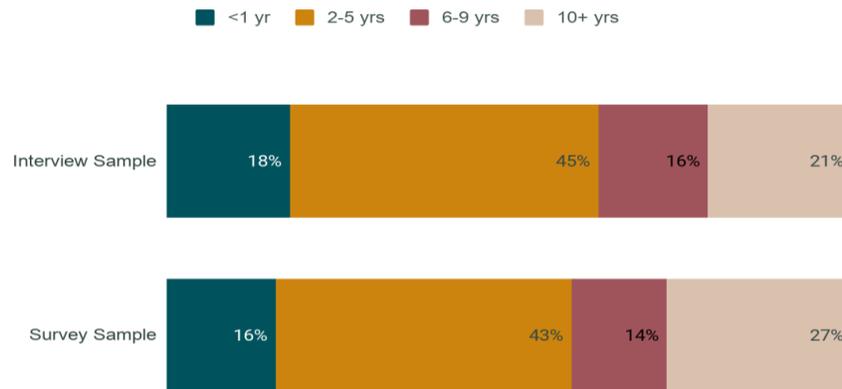


Figure 3: Years of Experience in Current Position



Current role in the system. A list of potential key informants was generated by the DHS internal review staff in an effort to represent a balance of perspectives and as can be seen in Table 1 represent a balance of system experience, age group experience and geographic experience.

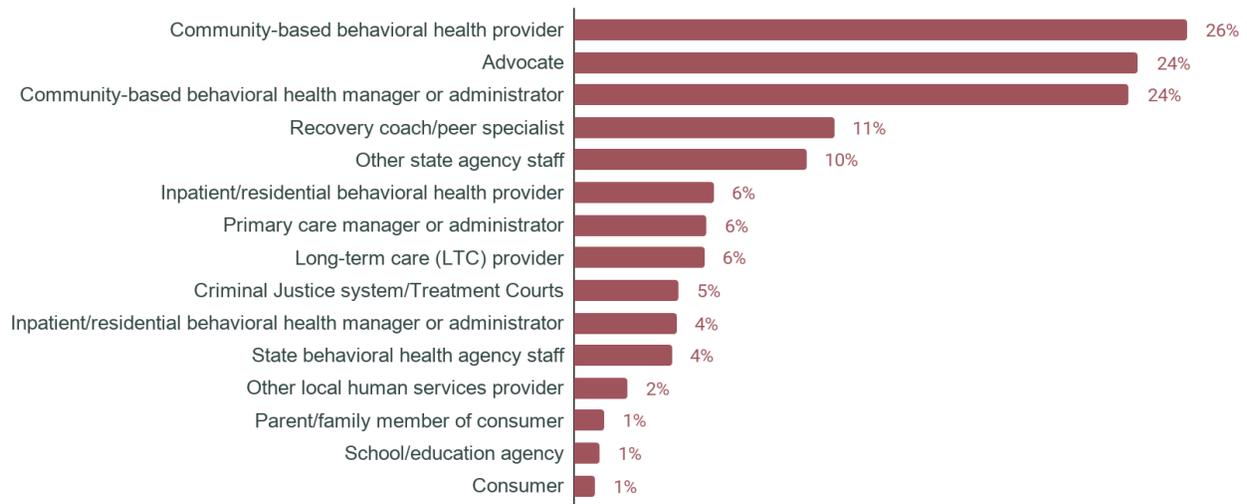
Table 1. Roles and Experience of Key Informants Interviewed

	BH system experience			Age group experience			Geographic experience*		
	MH	SU	MH & SU	Youth	Adult	Y&A	Rural	Urban	R&U
TOTAL Interviewed (N=39)	28% (11)	21% (8)	51% (20)	15% (6)	31% (12)	54% (21)	23% (7)	29% (9)	48% (15)
State DCTS staff (n=8)	2	3	3	1	5	2	N/A	N/A	N/A
Other state agency staff (n=8)	1	--	7	1	--	7	3	1	4
County BH admin (n=4)	--	--	4	--	--	4	1	2	1
County BH program managers (n=2)	--	--	2	--	1	1	1	1	--
Direct service providers (n=11)	5	3	3	3	3	5	2	5	4
Advocates (n=6)	3	2	1	1	3	2	--	--	6

Note. *= Discrete data not available for staff working statewide. However, 20 interviewees indicated the ability to speak to statewide patterns.

Survey recruitment cast a broader net in terms of role played within the system, and accordingly had a greater diversity of roles played within the system and experience in the different arms of the system included in this gaps analysis (i.e. MH and SU services). Whereas state staff made up half of the key informants, as can be seen in Figure 4, staff affiliated with the state only composed 14% survey respondents with community-based providers or managers making up just over 50% of the survey sample.

Figure 4: Survey Respondent Roles in the Behavioral Health System, by Percent of Cases Reporting



Nevertheless, the perspectives represented in the survey data suggest that each role represented had equal representation in answering questions regarding each service array (see Table 2 for counts and percentages of each role reflecting on gaps in needs regarding each array of behavioral health services).

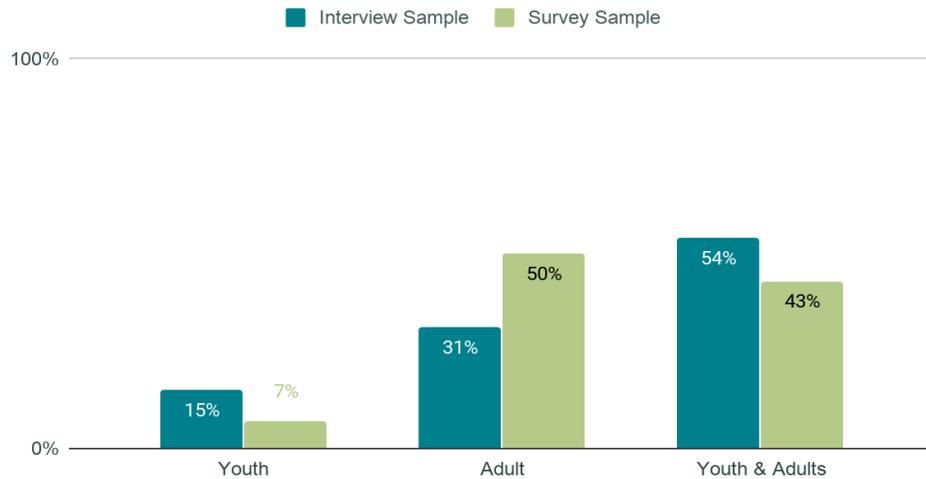
Table 2. Roles Represented by Survey Respondents

Role in Behavioral Health System	Total respondents N (%)	Cases prepared to reflect on types of service arrays	
		MH surveys N (%)	SU surveys N (%)
Community-based behavioral health provider	293 (27)	279 (26)	183 (24)
Advocate	270 (25)	266 (25)	165 (22)
Community-based behavioral health manager or administrator	265 (24)	259 (24)	211 (28)
Recovery coach/peer specialist	124 (11)	118 (11)	100 (13)
Other state agency staff	111 (10)	107 (10)	78 (10)
Inpatient/residential behavioral health provider	67 (6)	63 (6)	41 (5)
Primary care manager or administrator	63 (6)	62 (6)	42 (6)
Long-term care (LTC) provider	62 (6)	62 (6)	26 (3)
Criminal Justice system/Treatment Courts	50 (5)	45 (4)	49 (6)
Inpatient/residential behavioral health manager or administrator	49 (4)	45 (4)	32 (4)
State behavioral health agency staff	47 (4)	43 (4)	35 (5)
Other local human services provider	26 (2)	26 (2)	17 (2)
Parent/family member of consumer	14 (1)	13 (1)	5 (1)
School or educational Agency	12 (1)	12 (1)	8 (1)
Consumer	10 (1)	10 (1)	5 (1)

Note: A total of 1103 individuals answered both the questions regarding the role they hold in the system and what arm of the system they feel prepared to reflect on (i.e. mental health or substance use services). Respondents could list more than one role, and many completed the questions in the survey regarding MH services and questions regarding SUD services resulting in N=1062 Mental Health Service surveys started and N=754 Substance Use Service surveys started. As a result, while 1103 different people completed the survey, a total of 1816 surveys were completed, thus, totals will not equal 100%.

As seen in Figure 5, the vast majority of respondents had experience with the adult BH service system. In both data sources, a minority of respondents had experience with only the youth service system.

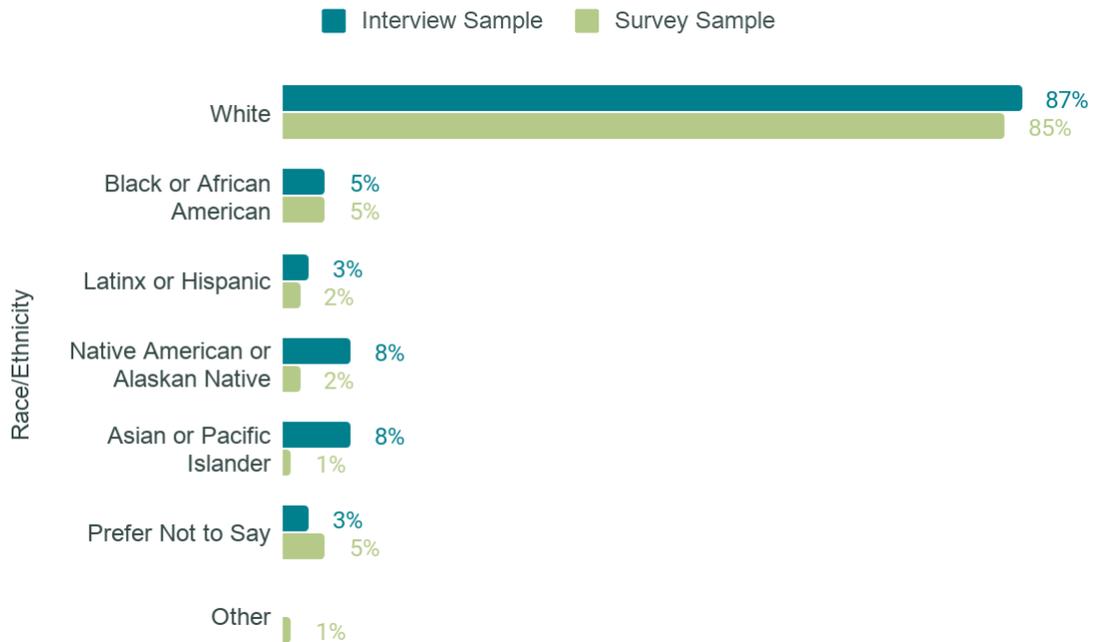
Figure 5. Adult and Youth Service System Experience



Demographics of interview and survey respondents. The survey concluded with a series of questions about respondents’ personal backgrounds. Both the interview and survey respondents were primarily white (85% and 87%, respectively) and both samples largely identified as women (65% and 78%, respectively) and cisgender (92% of the survey respondents). Less than 1% of the survey sample identified as genderqueer or agender (n=4), 0.5% identified as transgender (n=3), while 4% “preferred not to say” (n=44). Our sample of key informants exclusively identified as cisgender. Finally, of the survey respondents, just over 5% of respondents identified as lesbian, gay, bisexual, queer, questioning, or asexual (LGBQA).

Respondents were asked to indicate all of the racial or ethnic groups that aligned with their identity (Figure 6). The majority of respondents (85%) identified as White, with Black or African American being the next largest group (5% of respondents). Latinx, Hispanic, or Latin Americans; Native American or Alaskan Natives; and Asian or Pacific Islanders each comprised about 1% of the sample.

Figure 6. Racial/Ethnic Composition of Interview and Survey Respondents



Note: Respondents could list more than one race/ethnicity. Totals will not equal 100%.

Demographics of consumers who participated in focus groups. The sample of Wisconsin residents in this evaluation were primarily Black, Indigenous, People of Color (BIPOC) and varied by age, gender identity, and sexual orientation (See Table 3 for more detail).

Table 3. Consumer Focus Group, Survey, and Workshop Demographics

Partner Organization	Population	Number of Participants
Beloit (Rock County)		
Beloit College	BIPOC/LGBTQ+/Living with Disabilities	1
Whitewater (Walworth County)		
Alpha Kappa Alpha	BIPOC/LGBTQ+/Living with Disabilities	5
Wausau (Marathon County)		
Faithful Consulting LLC, Hmong Mutual Aid Association	Hmong (Elders)	8

Milwaukee (Milwaukee County)		
Hmong American Women’s Association	Hmong (Youth)	8
New Hope	Black/Latinx (Youth)	6
Diverse & Resilient	Black trans women	10
CORE El Centro	Latinx (18)/white (1)	19
Salvation Army	Men experiencing homelessness	9
Open Call	BIPOC/LGBTQ+/Living with Disabilities	5
Independence First	Deaf & Hard of Hearing (survey)	6
Aurora Walker’s Point Community Clinic	Chin, Rohingya, and Burmese Refugees (workshop)	6
Total Number of Participants:		83

Note. BIPOC= Black, Indigenous, Person of Color; LGBTQ+= Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and others.

Data Analysis Strategy

Findings from qualitative data were developed using thematic analysis. Thematic analysis is an iterative process of pattern recognition, where relevant information shared in interviews is compared across participants and distilled (Fereday & Muir-Cochrane, 2006). This process utilizes both deductive and inductive coding techniques to answer the evaluative questions posed by the internal review team.

The purposive sampling for informant interviews resulted in a group of informants with distinct professional expertise and perspectives. Accordingly, in our analysis, a single comment was considered as potentially important as those that were repeated.

The findings from analyses of the three data sources were integrated in the following manner. First, results from the key informant interviews were described to provide a nuanced and detailed account of the current state of the behavioral health system from a state-level perspective. Second, survey data findings were woven throughout to substantiate results from key informant interviews. Ideas that came up repeatedly across data collection methods were given prominence, as they likely reflect concerns relevant to many

stakeholder groups. Following the equity principle that directs us to center the voices of those most impacted by the shortcomings of social institutions, data from the hypermarginalized consumers who participated in the focus groups was given priority in the description of the findings below.

Findings

The results of this gaps analysis are presented as follows. After reviewing the themes in overall service and workforce gaps reported, the various barriers (i.e., payment and insurance; geographic; system coordination; service adequacy; and cultural barriers that contribute to the gaps in who receives treatment are reviewed. The final section reviewing the themes in gaps in Wisconsin’s behavioral health services focuses on the mechanisms that lead to health inequities through gaps in treatment. Each section on gaps and barriers is paired with a list of targeted solutions recommended by stakeholders to address each specific gap or barrier. Finally, the report concludes with a list of the actions prioritized either across data sources or highlighted as a solution that addresses the root causes of health inequities resulting from gaps in the behavioral health system of services to address mental health and SU needs. Note that unless specifically addressed, all findings are in reference to the behavioral health system of services that address mental health and SU needs as a whole. Similarly, if a specific population is not highlighted, the finding pertains to all potential consumers of behavioral health services.

The reader is advised to keep in mind that this report represents the perceptions of those who provided data. It is anticipated that this largely reflects real-life, however, as is highlighted in the limitations section, there are biases in most data collection endeavors. As a result, some of the findings reported may reflect common misunderstandings regarding how the behavioral health system works rather than reporting on how the system actually works. This, too, is helpful information to have as it points to the need to address misconceptions regarding the actual opportunities and constraints provided by current system functioning. When possible, known misunderstandings are clarified with facts, such as the incorrect citation of a state administrative rule.

Service Array Gaps

In the surveys, respondents were asked to rank each in a list of 18 services based on “how large of a gap there is between service need and service availability in the area(s) where [they] work.” The service with the greatest gap between need and availability was ranked 1, and the one with the least was ranked 18. Mental health (MH) and substance use services (SU) were listed in two separate questions, which respondents completed based on their area of expertise. Similar to interviews, psychiatric prescription or medication management was the most highly ranked gap in MH services. Psychiatric inpatient hospital services and crisis intervention and stabilization were also in the top five. See the Technical Report available on the DHS website for the full rankings of service array gaps.

Table 4. Greatest Substance Use and Mental Health Service Gaps, by Rank

Rank	Substance Use Service Gaps	Mental Health Services Gaps
1	Integrated MH and SUD treatment	Psychiatric prescription services or medication management
2	Sober housing	Crisis intervention and stabilization services
3	Residential treatment	Integrated MH and SUD treatment
4	Transitional residential services	Transportation
5	Detoxification services	Psychiatric inpatient hospital services

Possibly reflecting regional lack of service access, respondents also highly ranked transportation as a gap. Integrating MH and SUD treatment was highly ranked for *both* MH and SU services. However, it was the top gap for SU services and only the third most highly ranked gap for MH services (See Table 4).

In interviews, people in the SU service field noted that most people with SU challenges also faced MH issues. As one person working in both MH and SU services recounted, “[The] co-occurring disorders that a lot of individuals experience, it’s pretty rare that you’re going to get somebody with just a SU disorder.” However, the reverse pattern did not emerge in this study. This may contribute to the higher priority given to integrated care by those working in SU services. Sober housing, residential treatment, and detoxification services filled the other positions in the top five gaps identified for SU services. These responses indicate a need for increased facility-based and residential care in the SU field.

Among the MH services listed, the lowest ranked services (those perceived to have the smallest gap) were evidence-based practices, day treatment, health promotion, peer specialists, and recovery support services. For SU services, the lowest ranked items were drug of choice specific programming, SU commitments and court orders, and vocational services.

Specific Gaps in Inpatient and Residential Treatment Services

The most commonly cited services that were needed but not covered were residential and inpatient SU and MH services. Broadly, inpatient services are hospital-based and include 24-hour monitoring, while residential treatment tends to consist of longer-term facility-based services for consumers with less acute behavioral health conditions and medical needs. Some interviewees reflected on the history of this gap in Wisconsin, which is linked to the deinstitutionalization of individuals with MH challenges in the late 1970s. The 1976 Mental Health Act set forth stricter standards for involuntary commitments to care institutions, coinciding with normative shifts towards outpatient and medicalized care for individuals struggling with

mental illness (Erickson, Vitacco, & Van Rybroek, 2005). Residential substance use services have not been a covered service under Medicaid historically which has contributed to the lack of access, especially for low-income individuals.

Key informants described a need for residential and inpatient care that exists for individuals struggling with severe mental illnesses as well as those with co-occurring MH and SU challenges. Some drew a parallel between this gap and the lack of parity between behavioral health and conventional healthcare. As one person working across MH and SU services in rural Wisconsin described, “[If] you go for a hip replacement, you might spend a week in a residential facility getting cared for before you’re ready to go home on your own. We don’t have that service for MH or substance abuse.”

“Wisconsin does not have a lot of residential/inpatient substance use services, and the ones that [it] does have are slim and spread throughout the state. This causes consumers – adults and youth – to have to leave their families and stay somewhere unknown to themselves, for long periods of time. Which, in turn causes those to not seek treatment for fear of the system and fear of being alone and isolated in an unfamiliar place. Hospitals need to open their inpatient services back up, and the state needs to fund more peer run respite in various counties to have alternatives and additional beds [rather] than just inpatient psych wards.”

Certain inpatient and residential services are not currently covered under Medicaid. The Institutions for Mental Diseases (IMD) exclusion rule prohibits Medicaid reimbursement for adults between the ages of 21-64 receiving services in large psychiatric treatment facilities with 16 or more beds. One man in rural Wisconsin reported, “[Right] now, Medicaid does not reimburse the costs of ... being treated in a psychiatric hospital, and that’s at about \$1300 a day. ...[This] can have a huge financial impact on our county mental health system.” Although grants are able to fill some funding gaps, respondents noted that grant funding is relatively unstable over time, making it difficult for organizations to do long-term planning and investment. Additionally, the only coverage for residential substance use services under Medicaid is within the CCS program, which covers only non-IMD’s.

This benefit is only available to the small percentage of Medicaid-covered individuals that are eligible for CCS. All other Medicaid-eligible individuals have no access to residential substance use treatment under Medicaid, regardless of IMD status of the facility.

“There simply are not enough residential mental health options available across the state. In rural areas, for example (and Wisconsin is FULL of rural), there is absolutely nothing available. With the exception of an occasional group home – which is not appropriate for everyone and is almost always full.”

Gaps in residential and inpatient SU treatment facilities are widespread, but some regions may feel these gaps more acutely. One person observed, “[If] you draw a line from [Appleton] up toward the top corner of the state, the top western corner of the state, there’s a lot of area with very few services.” This was echoed by others, who emphasized the lack of youth and adult inpatient care and residential SU services in that area. Detox facilities were described as a gap in that northern part of the state, but also in rural Wisconsin

more generally. Access to residential treatment for many of the tribes was also highlighted as a severe regional gap. One person working in Milwaukee also noted the need for more residential services for families, and for sober living options, in Milwaukee and surrounding counties.

Some subpopulations face larger gaps in intensive services. Interviewees also indicated gaps in some specialized residential and inpatient services. Inpatient and residential MH options for adolescents, children under 12, the elderly, and individuals with cognitive delays and behavioral health needs are particularly limited. The absence of transition services for young adults aging into the adult programs was also a noted gap.

Not all residential MH facilities embody a focus on recovery. Many of our informants were concerned about the quality of services at residential and inpatient facilities. While noting that staff are likely very overburdened and facilities may be at or over capacity, some were concerned that the conditions of care in some facilities may lead to trauma for some consumers. Especially for consumers involuntarily committed to a facility, if the conditions of care do not help stabilize or improve your mental health, being locked up involuntarily seems unnecessary and may contribute to worsening your health. Others had the impression that physicians and other staff working inside MH facilities were not coordinating with a consumer's community outpatient provider on a treatment plan. One survey respondent argued, "There needs to be more oversight of the inpatient units at local hospitals. They discharge clients too early; they change meds without consulting outpatient providers, they treat outpatient providers poorly, and are generally not very collaborative."

Because of the lack of voluntary residential and inpatient facilities for youth, the emergency detention process may be misused to obtain services. A subset of respondents

"A place to stay does not mean treatment, and it is difficult to find a place for high needs clients to stay, let alone get proper treatment when they are there."

who identified a gap in residential care also discussed the lack of inpatient services for youth. They described situations across the state where youth experiencing severe behavioral health needs are being sent through the emergency detention process even if unwarranted, in part because of the lack of residential and inpatient services for youth. One person working in MH services reported, "I would say, there are so few beds, that we have run into situations every year where there are no beds available in the entire State of Wisconsin outside of those that are held for kids that are on [emergency] detentions.... But if it's a voluntary basis, it's hard. The facilities just simply don't exist." Not only is emergency detention an inadequate response to the care needs of young people, interviewees felt the detention may be causing harm, even if the youth ended up being connected with behavioral health services. Along these lines, another survey respondent suggested that youth be allowed "access to residential treatment without having to go through court [as] this deters parents from [the pursuit of] needed services due to fear of stigma and loss of control of decisions about their child."

There is a need for more residential SU services and sober housing. The lack of residential SU services, particularly detox, have significant downstream effects on patient outcomes. One person working in the field of SU services recounted, “There's a lack of services for withdrawal management or detox services, so when someone decides they want to seek treatment for their SU disorder ... they need medical assistance to go through the withdrawal process and there just are not facilities that do that. Hospitals have no idea what to do. People show up in emergency rooms and basically don't receive the services they need, and they continue to use.”

Sober housing and housing in general for individuals with SU needs also came up in interviews as a needed form of relapse prevention and holistic support. One individual working in rural Wisconsin in both MH and SU services observed, “For people who have significant MH and SU challenges... [they] may need a little more than the average person as far as support when they're back in housing, especially in an early recovery. There are almost no resources for them currently.”

There are no residential SU or detox options for adolescents. More than one interviewee noted a gap in “the higher level of care for children or youth that have an SU issue.” However, the need to fill this gap was not unanimous. As another person who had worked in SU services for over 20 years argued, “I think when we talk about youth services, people are like, ‘There's not enough youth SU services. We need a youth residential treatment.’ Honestly, I probably only ever in my career would have sent maybe a couple kids to a youth residential treatment. They're just not, their use hasn't progressed enough to be at that level.”

Parents in need of SU support have few family-friendly options. Adults with young children face additional challenges to accessing residential SU treatment. In talking about Waukesha and more rural areas around the state, one individual working in the SU system noted that “they have a very few number of residential facilities for SU. They have even fewer sober living situations. ...They have only two facilities that mothers can take their children, and they may be limited to the number of children they can take when they go into treatment.” The gaps in child-friendly treatment options limit the ability of individuals struggling with addiction to make a sustainable recovery, particularly people who have children or live in less populated areas of the state.

“Where providers are not local, the time that it would take a parent to leave work, pick up their child, travel to a provider, have the appointment, drop off the child at home/school and return to work is no financially viable, especially where care is needed frequently.”

Insurance limits coverage of required assessments for inpatient treatment. Providers shared the concern that specific assessments required for covered services are not themselves covered. This unfairly disadvantages low-income consumers, who may not be able to pay out of pocket for the assessments necessary to access inpatient services.

Many local hospitals refuse to offer detox services. In both surveys and interviews, a common frustration shared was that though facilities with the capacity to offer detox are present, hospitals decline to admit

consumers except when their health is in immediate crisis. Additionally, there were several comments about consumers being turned away for chronicity; situations wherein hospitals will monitor but not extend detox support because, “they’ll just drink again.” In other cases, hospitals reportedly only offer detox services for specific forms of substance abuse: “Not all substances meet medical necessity criteria for a detox admission (like opiates).” Specifically, clients using IV drugs, and stimulants who seek treatment were often noted as being denied access to inpatient treatment. In place of treatment, providers report that hospitals are “sending addicted clients home with medications they often abuse and not enough support to help them take the next steps.” This appears to be another area wherein providers are forced to escalate a voluntary case to an emergency detention simply to acquire services: “people are not allowed into detox without first going to a doctor or are brought in by a law enforcement officer.” It was noted that some consumers are being denied care until they are involved with law enforcement: “IV drug users do not have many inpatient treatment options and are often incarcerated before treatment is an option offered to them.”

Stakeholder Recommendations: Improve Inpatient and Residential Care

Use state/federal funding for start-up costs to expand services, particularly in the NW. Several respondents felt that the state could play a role in financing capital expenses for the construction of new residential facilities. One person, focusing specifically on residential elder care, suggested, “I don't think that money is the solution to absolutely everything. But at the same time, if there's some startup funding available or maybe just general funding, grant opportunities, etc., so that providers can retrofit a facility or build a facility to meet the needs of our elders, I think that would go a long way.” This proposal could also apply to other residential services, to help counties and regions fill gaps in their service array. The recommendation to reduce operating costs, including providing funding for start-up costs, was proposed by a quarter of all survey respondents in open-ended responses. This suggestion may be especially relevant for rural and northern areas of the state, which lack service infrastructure. Similarly, startup funding could benefit less-intensive services and open up space in existing residential and inpatient treatment facilities: “create infrastructure and services for intensive outpatient and day treatment levels of care and sober living services. There is nothing here but outpatient.”

Increase the number of general hospitals with psychiatric units. One route for improving access to inpatient care is to increase the number of hospitals that have beds available and increase the number of beds they have. One interviewee put this at the top of their list of priorities saying, “[The] first thing we need to change is having more general hospitals that have psychiatric spots.” The state could also put pressure on hospitals to provide inpatient behavioral health care through Medicaid contracts, or other incentives. One person recounted, “[We] have two hospitals, high tech tertiary care and minimal to no psychiatry. They can do high-level brain surgery, highly recognized heart surgery, whatever. Almost no behavioral health services and yet they're affiliated with Medicaid managed care contracts. That's unacceptable.” Another person suggested requiring that “if you [a hospital] become the medical health home for somebody you're obligated to have enough psychiatry and behavioral health services to care for that person also.”

Residential mental health services are so important, but they are not able to stay afloat in smaller areas. They end up having to close down which then leaves their patients stuck as to where to go. And if they can't get to a new place, they are more likely to fall back into old habits."

Work with hospitals to accept more voluntary commitments for inpatient mental health care. There was also a sense among some respondents that hospitals were refusing to accept patients committing themselves to treatment on a voluntary basis. This

forced some providers to escalate to an

involuntary commitment, solely for the purposes of getting someone into inpatient care. One person working in MH in rural Wisconsin said, "I think it's possible that we could do fewer Chapter 51s in the state if more hospitals were willing to accept individuals on a voluntary basis." She (and others) also suggested that hospitals wouldn't hold beds for voluntary commitments "because of their belief that [patients will] get on the unit and then they're just going to leave." Some mentioned this in the context of implicit bias, wondering whether this pattern of denial of voluntary commitments had to do with administrative biases towards individuals having a MH crisis. Regardless, it seems there is room for the state to intervene to reduce the use of involuntary commitments in cases where it isn't warranted.

Include coverage of residential SUD treatment services as a Medicaid benefit for all AND implement an IMD exclusion waiver. Funding was identified as a key part of the solution to gaps in residential and inpatient behavioral health services. Since only consumers eligible for CCS currently qualify for coverage of residential stay for SU treatment, an important first step is to offer this benefit to all consumers. A part of the current funding context is the Institute for Mental Disease Medicaid exclusion. One interviewee explained, "That's the rule that says that Medicaid can't pay for a facility in excess of 15 beds. That rule was never intended to be a barrier, it was supposed to eliminate the proliferation of large institutions, state-operated hospitals." Wisconsin has secured a Section 1115 Medicaid waiver to allow coverage of SU services in larger facilities, but the waiver has not yet been implemented. A similar waiver is now available for MH service facilities and has been secured by Washington D.C., Vermont, and Indiana (Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, 2020). One interviewee urged, "[The] people at DHS needed to be prodded and say, 'Yes, we would like to pursue that.' I think it's through a waiver. If ... there's an option that the MA will pay for it rather than the county, I think that's a no-brainer. They should have put that as a priority."

Create a separate administrative rule for adult residential crisis stabilization. Interviewees celebrated the recent creation of an administrative rule defining youth crisis stabilization, an important step toward making that service accessible. One respondent suggested that a similar rule for adult residential crisis stabilization would go a long way: "I wonder if they'd be more common or easy to open or more fiscally sustainable if there was an administrative code or even just add a section to the CBRF [community-based residential facility] code or something that just makes it a little more clear, a little bit easier... to open one of these facilities up."

Specific Gaps in Community Outpatient Services

Community outpatient services include a range of treatment options that help keep the consumer in the community, rather than providing care in restrictive environments.

Due to insufficient availability of outpatient services, “Too many people who could benefit from outpatient services receive inpatient services.” In both the survey and key informant interviews, respondents identified that MH conditions worsen to the point where more intensive—and more expensive—treatment modalities become necessary as a consequence of inadequate availability of outpatient treatment options. One statewide children’s MH advocacy organization has highlighted that according to SAMHSA, Wisconsin’s rate of state hospital bed use for children and adolescents is approximately five times the national average. Further, Medicaid benefits are disproportionately allocated to institutional services, rather than to early intervention, prevention, and treatment.

“I feel the gap is getting the help they need BEFORE they enter an institute. Many are not able to get the meds they need or the help they are asking for before their offense. Families feel at a loss of what to do.”

Too few crisis stabilization beds and crisis diversion services. Several respondents also claimed that with the dearth of crisis stabilization services, families and other community members call law enforcement to intervene during a crisis. Even with training in crisis de-escalation, police will eventually default to arrest in order to isolate a person in crisis.

According to a nationwide survey of law enforcement agencies, the current practice of relying upon police to stabilize individuals in crisis is a strain on limited law enforcement resources. This study found that due to the limited number of inpatient beds and crisis stabilization services, when police are called to respond to an individual in psychiatric crisis or in need of transport to a facility, the officers have to drive five times the distance it would take to bring a person to a local jail, and on average wait 3 hours for admission to a medical facility versus 37 minutes for admission to a jail. According to a Wisconsin-based respondent, such a call is at least an 8-hour commitment, forcing an officer to make tough choices when another situation entailing threat of public harm arises (Treatment Advocacy Center, 2019). The use of specialized response centers has been found to reduce police frustration and decrease the arrest rates of persons in crisis with serious mental illness (Steadman et al., 2000).

Needed services are not covered by Medicaid. Interviewees and survey respondents highlighted that some necessary treatment services - such as providing crisis support for the support system of the individual in crisis- are not eligible for Medicaid coverage. Mentioned services include telehealth consultation services to primary

“... [Crisis] services are only provided to individuals in crisis, not their support system which, without education, increases the chances they will repeatedly use crisis services.”

care providers, transportation other than medical transport, SU supportive services by a recovery coach (rather than a peer advocate), and support provided to the family system of symptomatic consumers. During the study, 2019 Wisconsin Act 156 made SU services provided via telehealth reimbursable under Medicaid. More recently, 2020 Wisconsin Act 122 made peer recovery coach services reimbursable under Medicaid.

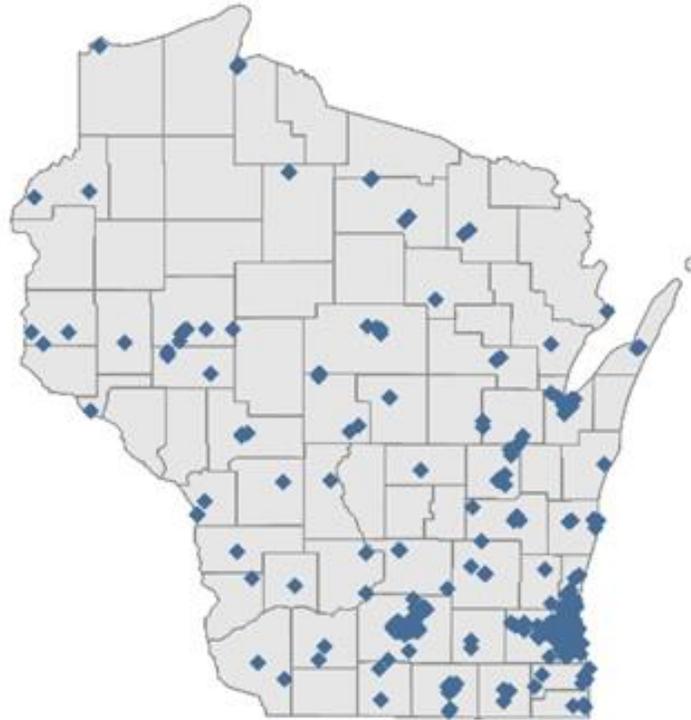
There is a statewide shortage in medication services. Most insurers require medication management visits with a psychiatrist every 3-6 months. As a result, the limited number of available psychiatrists are frequently booked solid with medication monitoring visits several months into the future, thereby limiting access for new consumers to be seen.

Insufficient numbers of providers are willing to provide MAT services especially in the North and Northwest parts of the state. A repeated theme that emerged in the interviews and surveys is the perception that medication-assisted treatment (MAT) is limited, in part, because of the stigma some providers hold regarding MAT and the individuals that need it. Some suggested that providers don't offer MAT because of a personal abstinence-only recovery philosophy. This perspective is summarized by one survey respondent, who wrote: "In [our] County, the strongest sober community is a group of Baptist Christians who discourage MAT because they say it's not real recovery and you wouldn't need MAT if you accepted god." Another respondent noted, "[MAT] is perceived as 'cheating' or 'just getting addicted to something else.'" There was also a perception that some providers believe welcoming in consumers struggling with addiction would reflect badly on their clinics. Finally, it was noted that methadone clinics/Opioid Treatment Programs in particular are for-profit and federally regulated, making it difficult for other entities to fill gaps where they exist.

"Being in a more rural setting does not draw prescribers to the counties that we serve. The average wait time to access services to see a prescriber is 3-4 months minimally. Some of this is also due to the fact that there is a severe shortage of them in the whole state."

The provision of MAT is particularly scarce in the North and Northwest regions of the state. Buprenorphine, for example, is a drug approved to treat opioid addiction and approximately 880 federally approved prescribers of buprenorphine exist in Wisconsin as of March 2019. Even with this capacity, the availability of slots and prescribers for this medication continues to impede efforts to provide or expand opioid treatment in many areas of Wisconsin. Figure 7 shows the distribution of buprenorphine prescribers in Wisconsin and their scarcity in the North and Northwest regions. Fifteen (21 percent) of Wisconsin's 72 counties do not have access to a buprenorphine prescriber.

Figure 7. Buprenorphine Prescriber Availability by Wisconsin County



Source: National Registry of Buprenorphine Prescribers

Regulations around telehealth limit providers offering this service. The regulations and MA reimbursement requirements for telehealth are one way the state ensures these services are safe, secure, and adequate to the needs of consumers. However, they are also barriers for organizations interested in providing telehealth services or expanding the kinds of telehealth they provide. Some interviewees pointed out the expense of initial investment in secure telecommunications infrastructure. A person working in rural Wisconsin across MH and SU services pointed out other regulatory barriers, arguing, “I need telehealth opened wide open. And what I mean by that ... We do a lot of telehealth. But I can't do telehealth groups. ... The way telehealth is required right now in this state, the patient has to come to my clinic. The provider can be anywhere they want to be, but the patient has to be at my clinic. Well, that doesn't really make any sense. I would like treatment to be as available as shopping on Amazon is.”

There are no outpatient options for people with intellectual disabilities and co-occurring MH needs. Survey responses reflected frustration with the lack of services equipped to support individuals with intellectual disabilities. Some noted that, “if IQ is below a certain scale, it is perceived as they are not therapy candidates which is affecting their ability to access psychiatric services locally.” Others felt that the disqualification of the individuals with intellectual disabilities from receiving CCS or CSP services is “discriminatory.” One man working across the behavioral health system in rural Wisconsin observed, “Ever

since we went to the Family Care Model, there is tremendous fragmentation between the MH system and the disability system. ... So often people are pushed from program to program, because they've carved out MH services from Family Care. Yet the people have needs in both systems. ... And nobody wants to be the one to provide it. That really impacts people with intellectual disabilities..."

Stakeholder Recommendations: Improve Community Outpatient Services

Broaden the base of potential MAT providers. In interviews, loosening provider licensing requirements was seen as a way to increase access to needed services, particularly MAT. A desire for the state to mandate (or encourage) the provision of MAT by SU service providers was voiced repeatedly. One person working across MH and SU fields suggested that the emergency non-medical codes could be expanded to include MAT, arguing, "[That] would be another way to incentivize people to do MAT." This change could help increase access to MAT across the state, particularly in places that don't have sufficient psychiatrists or federally approved prescribers.

Educate providers on the value of MAT and encourage revision of abstinence-only policies. As will be discussed in more detail in the section on stigma, there is a need for investment in provider education to reduce stigma regarding the use of medications to assist substance use disorder treatment. As one provider put it, "There is also the stigma against MAT itself where people do not entirely understand the function of MAT and the science behind it and thus reject it due to various reasons (e.g. seeing MAT as trading one addiction for another)." It was repeatedly suggested that primary care providers are an underutilized resource for addressing regional gaps in MAT services, if they are made more comfortable with prescribing medications like buprenorphine, Vivitrol, Campral, and naltrexone.

"Educate primary care physicians on M.A.T. I understand many do not wish to prescribe Buprenorphine as a regular practice, however, there [are] no specialized requirements for being able to prescribe Vivitrol. A PCP being able to prescribe and administer this in an office setting can greatly increase the availability of this option to someone in long term recovery."

Provide administrative support for in-school outpatient services. School systems were highlighted as a key ally, in terms of getting children and youth access to care. As of 2016, providers are able to bill for in-school, outpatient services for youth who might otherwise have trouble getting regular transportation. However, one person noted, "the school districts have to have the infrastructure to be able to support that. ... [Not] every school district has ... a system in place to do the billing," and that some school districts might be dissuaded by "red tape." The state could support the growth of this service model by increasing state funding for school-based services and by helping school districts navigate administrative barriers.

Support or incentivize innovations in crisis stabilization services.

Crisis stabilization was noted as a pivotal moment in a consumer’s episode of care. One common suggestion

“Provide respite and emergency/crisis care for parents/youth to have a break instead of law enforcement and crisis workers just getting a child to agree to go to bed for the night. Everyone needs a break in order to heal, and start fresh the next day; that is not being provided (there is no respite under CCS, only waiver which isn’t for behavioral health).”

was to develop innovative solutions that bring these critical services to the consumer. Respondents identified the value of utilizing satellite clinics: “Community based recovery centers that provide peer support services independent of the clinical model of care.” It was emphasized that all crisis stabilization resources should be equipped to handle dual diagnoses. “[We need] Mobile Crisis Response Teams - several in every county and add at least 5-6 short-term Crisis Response beds in every rural county.” One specific suggestion to improve crisis stabilization innovation is to provide grants to fund regional, potentially replicable pilot programs. One priority population identified for crisis services was adolescents, who need broader diversion and support options, particularly in the form of respite care for families to promote de-escalation and prevent police involvement.

Provide more feedback and oversight for existing crisis services. Providers frequently voiced frustration over the quality of crisis services. It was suggested that crisis services might benefit from greater guidance or coordination that comes with quality assurance monitoring. Specific ideas included, “increase state monitoring of county crisis programs- unannounced audits/site visits & chart reviews, verification of supervision, staff & supervisor credentials, solicit client and other agency/provider feedback.”

“In rural areas, crisis often happens completely over the phone and is often just a “stamp of approval” to hospitalize. There is no mobile crisis, no comprehensive crisis planning. With contracted crisis agencies or consortiums there is no investment to take time to truly provide crisis interventions.”

Reconsider telehealth access restrictions. Telehealth services are a critical opportunity to address gaps in community-based services such as peer support, outpatient counseling, group-based care, and day treatment via video conferencing. However, as many noted, the current rules governing telehealth require consumers to travel to a brick and mortar building. Altering regulations regarding the use of telehealth could enable consumers to more easily access care, including group sessions. Many felt this shift could be particularly useful for areas where services are few and far between, provided these areas have reliable technology.

Continue to advocate for LPCs and LMFT’s to be able to bill Medicare in Wisconsin. Certain national professional agencies, such as the American Counseling Association, have advocates [working] in Washington DC working on this issue; however, more leverage and buy-in is needed, especially from politicians and policy decision-makers.”

Workforce Gaps and Shortages

In addition to insufficient numbers of facilities to house providers across the service array, gaps in the behavioral health workforce came up as a major theme in interviews with staff across the state.

Psychiatrists, prescribers (like advanced practice nurse prescribers), therapists and counselors, social workers, and front-line staff were all highlighted as workforce gaps. The lack of diversity in the workforce was repeatedly identified as a major challenge.

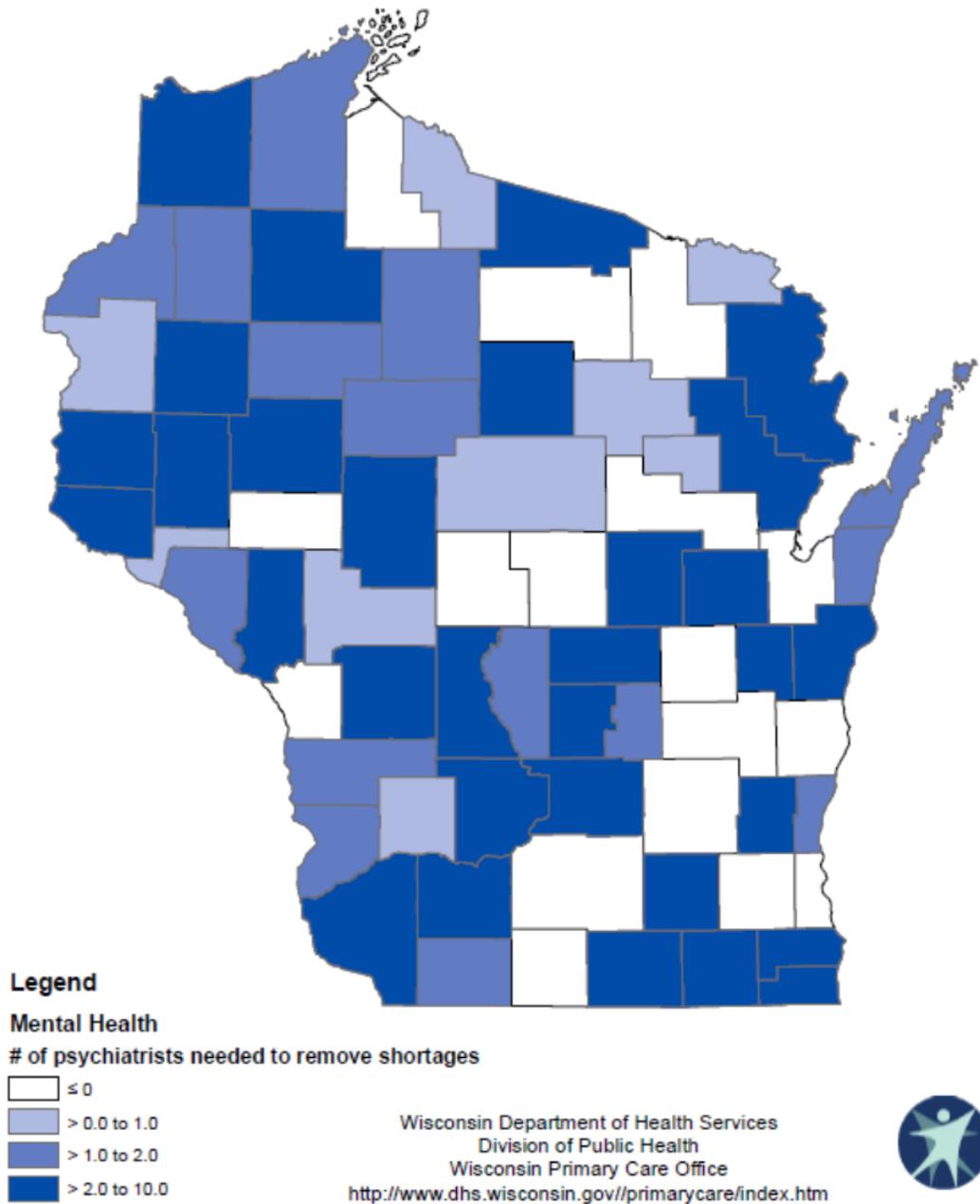
“We have more service gaps that substance abuse. Therapists are difficult to find; workforce is impossible to sustain and continuous turnover leads to a lack of service accessibility and lower quality services. The demand and need for services is high, but we don’t have [a] diverse enough workforce to meet the need.”

More psychiatrists and psychiatric prescribers are needed across Wisconsin. All but four interviewees discussed the lack of psychiatrists, and many of those individuals identified this lack as the most important workforce gap facing our state. Although many acknowledged that this workforce shortage is a national phenomenon, the gap is nonetheless acute. Wisconsin ranked 22nd in the nation in 2019 in the number of psychiatrists needed to relieve shortage areas (Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services). Interviewees noted that there are others who can be credentialed as psychiatric prescribers, most notably advanced practice nurse prescribers (APNPs). Although they saw this role as potentially filling the gap in psychiatrists, they also highlighted that there is a workforce gap in APNPs as well.

Respondent perceptions are confirmed by data describing the “significant” shortages in psychiatrists for each county which are tracked by the Wisconsin DHS Primary Care Office (Figure 8). A significant shortage means having a ratio higher than 10,000 people to one full-time equivalent psychiatrist. Out of 72 counties, 55 have significant shortages and 31 need more than 2.0 full-time psychiatrists to eliminate the shortage. Although 17 counties show no significant shortage, psychiatrists from some of these counties may spend part of their time serving individuals from surrounding counties. Thus, the number of psychiatrists may overstate the availability of psychiatrists in these 17 counties and understate the availability of psychiatrists in surrounding counties.

There is a critical shortage of child, adolescent, and geriatric psychiatrists. These professions represented the most acute workforce gap in both the interviews and surveys, above and beyond the gap in psychiatrists for adults. One person working in rural Wisconsin across both MH and SU services said, “We can’t get meds prescribed for people because we don’t have anybody qualified to prescribe anymore. It’s really hard in Milwaukee and in Madison. Imagine what it’s like to find a psychiatrist if you live in some rural community far from a major metropolitan area. ...I mean, we’re all together in this nightmare of no psychiatrists.”

Figure 8. Number of Psychiatrist Full-Time Equivalents Needed to Reduce Significant Shortages



There is a need for dually credentialed providers. A central gap noted across interviews and surveys was the shortage of providers who are dually credentialed in SU and MH care, or even providers who have some experience working with dually diagnosed individuals. It was emphasized that although SU training prepares the workforce to understand and treat MH concerns, MH training programs do not specifically cover issues specific to SU, thus leaving MH providers inadequately prepared to support the many consumers with a dual

diagnosis. Several respondents also indicated that the shortage of dually credentialed providers that are culturally competent in working with consumers not part of their culture is an even more dire situation.

“Too few substance abuse licensed professionals and compounded when you look at trained and licensed professionals working with minority populations”

Northwestern Wisconsin, and rural Wisconsin more generally, is perceived to face the most severe gaps in behavioral health services and workforce. Respondents from rural, urban, and suburban all discussed rural Wisconsin in interviews. Some felt that residents of rural areas faced different and/or more acute barriers compared to urban areas. Other interviewees suggested that rural and urban areas struggle with different, but equally pressing challenges. Nonetheless, there was a consistent pattern of Northern and Northwestern regions—specifically rural areas—being characterized as particularly under-resourced areas. Interviewees, especially those working in rural areas, issued a clear call for attention to the unique needs of Northwestern Wisconsin and less populated regions of the state.

The emerging workforce does not want to move to rural areas. Both interview and survey respondents shared the concern that rural areas do not draw the emerging workforce, particularly given current workforce conditions within the BH system. One survey respondent wrote: “Residential providers continue to close down across the state. There is not the workforce to support group homes in rural areas.”

Counties that don’t participate in CCS have untapped peer specialists. Peer specialists came up in interviews as both a gap and an important opportunity. Some interviewees specifically said they wanted to see more peer specialists involved in the behavioral health field in Wisconsin. Others noted that the state has made a lot of progress in training a workforce of peer specialists, which they saw as a step in the right direction. However, there was a general sense that this workforce is currently underutilized in counties that don’t participate in the Comprehensive Community Services (CCS) program. CCS integrates peer specialists into care, but according to interviewees, unaffiliated behavioral health organizations haven’t made full use of their skills and capabilities if they offer them positions at all. Currently, Medicaid doesn’t reimburse for peer specialist services outside of CCS and so this potential workforce is excluded from benefiting behavioral health programs outside of CCS.

Gaps/Shortages in Culturally Diverse Providers and Services

Culture includes a wide range of phenomena, including social norms, community knowledge, beliefs, art practice, laws, customs, capabilities and habits of the individuals in these groups. Culture impacts behavioral health in complex ways, including (but not limited to) the language of treatment; acceptable ways to handle stress, grief, and joy; and unspoken rules about navigating a conversation with a relative stranger. The cultural match of services refers to the extent to which individuals from different backgrounds feel comfortable seeking help and feel their needs are met when they do receive services. Three interlocking

conditions that lead to gaps in the cultural match of services were described by key informants—the lack of diversity among providers, the lack of culturally appropriate treatment and programs, and the inadequacy of translation services which will be discussed in more detail in later sections.

Behavioral health services are negatively impacted by the lack of diversity in the provider workforce.

Shared provider and consumer identity are positively related to consumers’ experience of care and

“[A consumer] can probably get in to see somebody but they’re most likely going to be white. And they’re most likely going to be a woman. Because that is our field. Which could be perfectly fine. Or not. So that choice is there.”

level of trust, both in medical and behavioral health settings (Street, O’Malley, Cooper, & Haidet, 2008; August, Nguyen, Ngo-Metzger & Sorkin, 2011). Additionally, providers’ implicit biases have been found to negatively impact both provider decision-making and the provider-consumer relationship (Penner, Blair, Albrecht, & Dovidio, 2014). These patterns were also reported in interviews. One person argued: “Sometimes the most critical piece is the trust. So even if you spend lots of money to get me there and I get there and the people there don’t look like me, don’t speak my language, can’t understand my terminology, I would disappear, and I don’t come back because I don’t trust that you can help me.” This sentiment was reiterated in the survey responses, where one person wrote, “Lack of diversity in service provision field makes historically marginalized individuals less apt to access services, which can increase stigma for individuals that do access services. “

Administrators struggle to hire minority providers. In a context of workforce shortages, organizations struggle to hire staff whose identities reflect those of the populations with whom they work. In some rural areas that do have a behavioral health provider available, the consumer population isn’t sufficient to support multiple providers. As one key informant working in both MH and SU described, beggars can’t be choosers: “Counties don’t have providers, period. So, if they don’t have that, they need to have that foundation before they can say, ‘Oh, and are you culturally aware of this cultural group? Or do you have experience in trauma informed care?’of course we want services to be culturally appropriate and recovery-oriented. But we don’t even have anything yet, period.” Until organizations are able to recruit providers whose identities reflect the populations they serve, behavioral health resources may not reliably reach and retain individuals from certain identity groups.

“[Our] workforce does not reflect the population we serve. ... [The] most in demand... are African American male therapists. And we can’t even come close to meeting the demand for that, there’s a very small number in the network, and they are all booked solid.”

Availability of culturally matched services is limited. Beyond the identity of providers, the cultural appropriateness of the services themselves were also identified in interviews as a key to gaps in adequacy. This encompasses gaps for populations like racial and ethnic minority groups, gender and sexual minorities, groups of differing abilities, youth, and some men. For these groups, culturally appropriate services may

mean thinking outside of the box of conventional models of care. As one person argued, “[When] we speak about culturally appropriate or culturally responsive services, we’re often stuck in a medical model where we just expect people to show up once a week to a therapist. ...And I think that for a lot of populations, that

doesn’t resonate.” Moreover, in the focus groups with hypermarginalized populations, participants emphasized that providers unfamiliar with their culture frequently balk at the idea of treating them.

“Distrust of emergency crisis line providers due to historical trauma and history of racism is a barrier that keeps American Indian people in this area from using county-run crisis lines. Conventional models of care don’t meet [the] needs of cultural minorities.”

Providers fluent in deaf and hard of hearing culture are particularly limited. Survey respondents pointed out the considerable barriers that deaf and hard of hearing consumers face when attempting to access adequate behavioral health care. The limited numbers of providers that are deemed “culturally or linguistically sensitive to the needs of the deaf, hard of hearing and deaf-blind” led one provider to declare, “Deaf and hard of hearing people have essentially zero options for qualified, truly accessible, direct-service providers in our state.” The limited number of qualified interpreters sparks a “strong fear that the few interpreters who work in MH will breach confidentiality and/or judge the person’s need for treatment.” Additionally, respondents indicated that when the provider is not culturally matched, they feel that assumptions and stereotypes about the deaf and hard of hearing community affect the treatment approach: “Often it is assumed that those who sign simply need interpreters and those who are hard of hearing simply

need amplification. The reality is that both require astute providers with specific training and awareness of the pervasive effect that hearing loss creates including identity, coping, effect on relationships and relationship dynamics (family, friends/associates, employers). Those who acquire hearing loss frequently experience an ongoing crisis state/confusion and lack knowledge of how to appropriately alter expectations and establish appropriate new norms.”

“Lack of knowledge and understanding of deaf people and American Sign Language. Also, lack of qualified interpreters able to do the work. Lack of qualified deaf professionals providing mental health services.

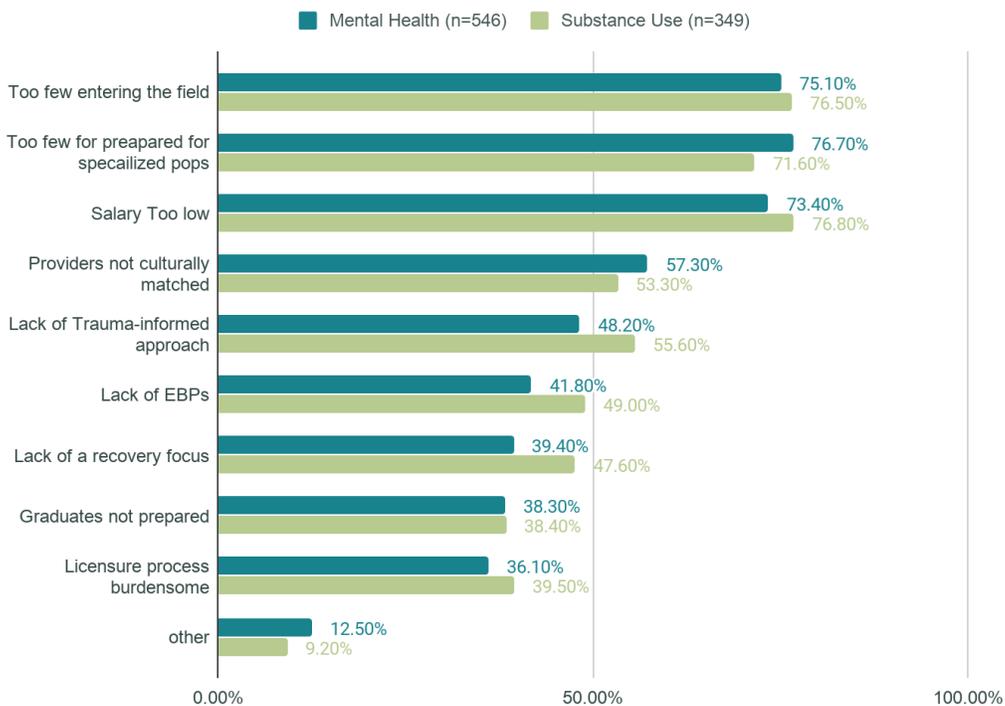
As a deaf person who works with interpreters all the time, it is not possible for me to get the services I need with a hearing professional, using a sign language interpreter, and as a deaf person who has professional ties with other deaf professionals, it’s not possible to have confidence in the few (less than a handful) deaf professionals providing mental health services. I am unable to get direct services with my peers, or with people who don’t know/understand my community, language and culture. This a significant gap for my needs.”

Workforce Conditions Contributing to Gaps in the Behavioral Health System

Toward the end of each section of the survey, respondents were asked to indicate which of a list of nine workforce conditions were contributing to the existence of gaps in MH or SU services. Respondents were also given the opportunity to fill in another pressing issue not represented in the forced choice options.

Below is a graph of the frequency with which each of the conditions was selected as contributing to the existence of gaps in MH and SU services, respectfully. For SU services, the most frequently mentioned workforce condition contributing to gaps in services was *Salary and benefit levels are too low to retain providers*, while this condition came in third for MH services. The second most frequently identified workforce condition contributing to gaps in SU services was, *an Insufficient number of providers entering the field to address workforce shortages*, and the third most frequently identified issue was an *Insufficient number of providers with the expertise to treat individuals with specialized needs*.

Figure 9. Workforce Conditions Contributing to Gaps in the BH System, by Service Area



For MH services the most frequently identified workforce condition contributing to gaps was *Insufficient number of providers with the expertise to treat individuals with specialized needs*, followed closely by *an Insufficient number of providers entering the field to address workforce shortages*, and in third place for frequency was *Salary and benefit levels are too low to retain providers*.

Potential outpatient MH providers disallowed by Medicare rules. Individuals with Marriage and Family Therapist (MFT) or Licensed Professional Counselor (LPC) licensing are not qualified for reimbursement by Medicare. It was the strong position of many providers who completed the survey that this is a missed opportunity to close gaps in the workforce and is a rule that should be revised.

“Medicare limits the type of providers that they cover, not accepting LPCs or LMFTs”

Child Psychiatry credentialing requires more school, more paperwork, but pays less than adult psychiatry.

According to key informants, the burden of becoming a psychiatrist with a specialty in children outweighs the benefits. Gaining specialization in children in psychiatry entails more schooling and thus more debt and yet pays less than working with adults, by comparison. Additionally, respondents highlighted that there is an onus of greater documentation requirements when working with children, which means fewer billable hours. It may be that some would-be child psychiatrists are dissuaded by this combination of factors when in medical school and before choosing their area of specialization.

Stakeholder Recommendations: Develop Infrastructure, Workforce and Workforce Diversity

This section summarizes suggestions interviewees made to address increasing the number and diversity of people in the behavioral health hiring pool.

Create pathways for career placement and professional development in underserved communities. The state has an opportunity to create stronger career pathways and financial incentives for newly trained behavioral health professionals to stay in Wisconsin, especially in rural and underserved areas of the state. A number of key informants interviewed suggested expanding residency opportunities as a promising approach for encouraging graduates to remain in the state. One interviewee highlighted that the Medical College of Wisconsin had recently expanded residency programs to sites in Northern Wisconsin, commenting: “That sort of paradigm needs to be done across all the health professions, particularly the behavioral health professions ... If you have more than X number of behavioral health social workers, you need to become a field placement.” Another person argued that funding residencies is “expensive, but they're not. In the grand scheme of things, think of it as an investment and don't think of it as an expense.”

Begin recruiting for psychiatry in schools, particularly among students of color. The public education system was identified as a key lever for expanding, diversifying, and improving the preparedness of the behavioral health workforce in Wisconsin. One avenue for change is revising curricula and increasing outreach in secondary, postsecondary, and professional education to increase student awareness of careers in behavioral health. Reflecting on the stark gap in psychiatrists in Wisconsin, one person said, “I think there needs to be more education to medical students about what psychiatry is and the need for it, the importance of it.” These outreach efforts are particularly relevant to the recruitment of diverse individuals into the behavioral health field. One professional working across MH and SU services argued, “[There] needs to be some active recruitment and retention of clinicians of color. And I really do think that starts even in high school and college ... to really actively encourage people to enter this field and support them with different resources throughout the journey so that they are prepared to identify that as a career path and stick it out.”

“Focus on people of color as often they are not given the same opportunities as the majority which then does not help with culturally responsive therapy for our community. Money in the forms of grants for POC therapists/agencies should be done.”

Offer loan repayment programs and tax incentives to all, reserving a portion of them specifically for early career psychiatrists of color. A

potential set of solutions to workforce

shortages that featured prominently in our data was to provide incentives to attract workers to the profession, particularly in rural areas of the state that struggle with recruitment. One person working in a rural area described how she was able to make a recent hire in part because of the National Health Service Corps program, which promised \$12,000 a year in loan repayment for the provider. She observed, “[When] you look at the debt loads that people are having as they come out of school now, it’s one of those things that can help attract somebody to an area that maybe isn’t really where they want to live. ... And then you hope that by the time they do their time with you, they love it and they stay.” Others suggested the resurgence of retired programs such as the Minority Health Training Program: “BRING BACK THE MINORITY TRAINING PROGRAM which allowed working individuals to obtain necessary training to go into the field on weekend or evening hours. This should be available to encourage participation and cultural diversity of workforce for both MH and SU”

“Promote psychiatry services in urban areas in Milwaukee. Consider working with agencies like the National Health Service Corps to attract providers by offering repayment of student loans.”

Increase provider pay. Without increasing Medicaid reimbursement rates for behavioral health services, interviewees predicted that it will be difficult to retain newly trained professionals in the public system (or in Wisconsin) after residencies or financial incentives run dry. One interviewee alluded to this “brain drain,” suggesting that Wisconsin “do a comparison of your Medicaid reimbursement rates with your surrounding states. Those are the ones that are more likely to drain some of our talent from here. So, let’s just find out if the playing field is level or not.” Another noted a similar challenge in the educational pipeline as well as the dynamics between the public and private behavioral health system: “[Reimbursement] of behavioral health providers relative to other healthcare providers likely reduces the pipeline of individuals becoming qualified as behavioral health providers and then is exacerbated at the public versus private level ... the qualified providers are then more likely to work or have the majority of their work in the private system.”

Expand the list of reimbursable activities. Survey respondents highlighted that the paperwork, supervision, consultations and the efforts to obtain prior authorization from insurance providers are activities that are currently

not eligible for reimbursement but are required, and thus take away time that providers could otherwise be using to provide services to clients that are reimbursable. The limited nature of reimbursable activities thus compounds the financial strain providers are under. There were calls to provide reimbursement for case management services, employment services, and the work it takes to coordinate services for the more complex patient populations.

“Increase reimbursement rates and include compensation for paperwork, consultation, supervision, and prior auths. These are essential functions of clinical care, but are not compensated and are creating very negative working conditions.”

Provide guidance to hospitals on how to integrate and fund peer specialists. Many key informants and survey respondents celebrated the growth of the peer specialist workforce in Wisconsin. However, those who touted this progress also noted that organizations could make better use of their unique skills. As one interviewee argued, “[We] do put a lot of money into training and certifying peer specialists ... I think we should take the money and scale it up to where it's everywhere, show the hospitals the efficacy of that, and then they eventually will absorb them and pay for them. And I think there's a lot of training that needs to happen for providers so that they understand the workforce.”

Populations Facing the Biggest Gaps

In both the interviews and the survey, stakeholders were asked to identify which unique populations faced the largest gaps in services and to reflect on the causes of these gaps for each population identified.

In the survey, respondents were given the opportunity to identify 3 populations from a list of 18 unique populations identified by the internal review committee as most in need of services and least likely to receive them. The most frequently identified population believed to be falling through the cracks in the BH system was individuals with co-occurring MH and SU diagnoses. The next three populations were transition-aged youth (i.e. 18-25 years old), then adolescents aged 12-17, followed by children under the age of 12. The fifth ranked population was people experiencing homelessness, followed by individuals with a history of trauma (see Table 5 for the full list of unique populations identified by survey respondents as falling through the gaps in the BHS). Note that the list reflects most frequently identified populations and so is subject to the perspectives of survey recipients who are mostly white, cisgender, female service providers.

Respondents were then asked to speculate on the causes of the gaps for the populations they suggested, and the following themes were identified. Table 6 does not reflect the exact rank ordering of populations falling through the gaps tabulated from survey responses.

However, it is imperative to note that ranking of populations reflects the sample makeup more than it reflects the true experiences of these populations. Since white women who are providers in the community outpatient service array were overrepresented in the survey, the perceptions of need held by this group will rise to the top based on sheer numbers. Moreover, given that consumers of color may not pursue BH services in the absence of culturally-matched providers or services, one would not expect white women working in community outpatient services to get a sense that racial and ethnic minority populations, or non-English speaking populations are falling through the gaps, as they are unlikely to encounter them in their practice. As such, the remainder of this section explores service gaps identified by key informants and survey respondents affecting demographic populations known to be currently underserved within the BH system. Further discussion of stigma and marginalized groups can be found in the section on Themes in Health Inequity by Population.

Table 5. Rankings of Unique Populations Facing the Largest Gaps

Unique Population	% of Respondents	# of Respondents
Individuals with co-occurring MH and SU needs	10.5%	197
Young adults/transitional age youth, ages 18 to 25	9.5%	178
Adolescents ages 12 to 17	9.0%	168
Children up to age 12	8.6%	160
Individuals experiencing homelessness	8.1%	151
Individuals with a history of trauma	6.3%	118
Older adults, ages 65 and above	6.2%	115
Individuals with intellectual or developmental disabilities	5.4%	102
Undocumented individuals	5.1%	96
Incarcerated individuals	4.9%	91
Non-incarcerated individuals involved with the criminal justice system (e.g. on supervision, out on bail, formerly incarcerated)	4.0%	75
Trans, genderqueer, two-spirit, and intersex individuals	3.2%	60
Black/African American individuals	2.7%	51
Lesbian, gay, bisexual, asexual, and queer individuals	2.3%	43
Deaf and hard of hearing population	2.1%	39
Individuals with chronic illnesses	1.9%	36
Veterans	1.9%	35
Hispanic/Latinx individuals	1.7%	31
Refugee populations	1.2%	22
Hmong individuals	1.1%	20
Individuals using injection drugs	1.0%	15
American Indian individuals	1.0%	15
Multiracial individuals	0.4%	8
Pregnant individuals	0.4%	7
Other Asian and Pacific Islander individuals	0.2%	3
Individuals with HIV	0.1%	1

Table 6. Causes of Behavioral Health Gaps by Population

Population	Causes of Gaps in Services
Co-occurring MH/SU	Workforce shortage Needed services not covered
Youth and young adults	Workforce shortage Stigma and prejudice Cost is the barrier Are unaware of support options Needed services not covered
Individuals facing homelessness	Re-housing services/affordable housing Workforce shortage Stigma and prejudice
Older adults	Workforce shortage Stigma and prejudice Geography Lack of appropriate community services
Racial/ethnic groups	Lack of culturally appropriate services Stigma and prejudice Fear of governmental authority
LGBQA/TING	Lack of culturally appropriate services Stigma and prejudice
Co-occurring BH & dev./int. disability	Medical model not a good fit Needed services not covered Lack of appropriate community services
Veterans	Workforce shortage Geography Needed services not covered
Criminal justice population	Lack of reentry support for returning citizens Needed services not covered Stigma and prejudice
Other: DHH; chronic illnesses; without insurance or insufficient insurance coverage	Workforce shortage Lack of culturally appropriate services Stigma and prejudice Unaware of support options Needed services not covered

Note. LGBQA= Lesbian, Gay, Bisexual, Queer, or Asexual. TING= Transgender, Intersex, Nonbinary or Gender nonconforming. DHH= Deaf or Hard of Hearing.

Many of the ranked populations above and those discussed below have been found to have higher prevalence rates of mental health and substance use needs. When examining service gaps, half of the equation includes available services and the other half includes the level of need, or prevalence of need in the population. Table 7 lists the top ten populations that have the highest rates of mental health or substance use needs above the national average. Corroborating respondents’ list of ranked populations with service gaps, national survey data estimates the rate of “any mental illness” (AMI) and substance use disorders are highest in the corrections populations. Other populations with higher than average AMI rates that also were ranked high for service gaps include individuals who are multi-racial, young adults, and who have co-occurring SU needs. Additional groups ranked highly for service gaps that also have higher than average substance use disorder (SUD) national rates include individuals who are homeless, LGBTQA, and who have co-occurring mental illness.

Table 7. Population Groups with Highest MH/SU Prevalence Rates

Mental Health Population Group	AMI Prevalence Rate (%)	Substance Use Population Group	SUD Prevalence Rate (%)
County Jails	64.0	Corrections (Adults)	56.0
Corrections (Adults)	50.1	Homeless	34.7
SUD (Adults)	45.6	Corrections (Juveniles)	35.1
Homeless	45.0	County Jails	32.0
Lesbian, Gay, or Bisexual	37.4	Trauma	21.5
Two or More Races	28.6	Mental Illness	18.3
Unemployed	26.6	Pregnant	16.6
Ages 18-25	25.8	Lesbian, Gay, or Bisexual	16.4
Poverty	25.6	Native American	12.8

Source: Wisconsin DHS, 2019.

Individuals with Dual Diagnoses

Repeatedly, the concern that individuals struggling with both mental health diagnoses and substance use disorders were identified as falling through the cracks in a system designed to treat these two needs in isolation. From separate administrative statues to separate credentials, as will be discussed throughout this report there are many challenges to serving a person with co-morbid needs in the current BHS. This is not a Wisconsin-specific challenge, and as has been noted by the federal government, suicide and early mortality rates are disproportionately high among the dually-diagnosed, prompting the National Association of State

Mental Health Program Directors to issue a brief on “Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What Now?” (See Minkoff and Covell, 2019 for more detail).

Children and Young Adults

Across data sources, a concern about access and awareness of appropriate services for individuals ages 25 and younger was common in response to

“For children the issue is lack of access to treatment through the school system and there can be an unwillingness to recognize symptoms.”

the question regarding specific populations falling through the gaps in services. According to SAMHSA, Wisconsin’s rate of State hospital bed use for children and adolescents is approximately five times the national average. As one interviewee suggests, this reflects inadequate early intervention, prevention and treatment, and this concern was widely shared. For example, via the survey, respondents shared the concern that services for people up to age 25 are lacking and, at-times, in direct contrast with best-practices. For example, one respondent shared the concern that the waiting lists for children 12 and under are exceptionally long and often led to services that are not recommended for this developmental stage, such as individual therapy for children under age 8. As one interviewee noted, “whenever there’s budget cuts at schools, school psychiatrists, psychologists, social workers are often cut first. And to me, these schools [are] the first line of service for a lot of kids that are struggling.”

Another common concern raised in the survey was the belief that individuals under age 25 are unaware of how to secure care on their own. Once they age-out of being covered by an adult’s care, they are sometimes in need of more intensive services to treat: “17-25 [year olds] are so far behind and have so many strikes against them and self-esteem is ruined by [the time they qualify for Medicaid independently]. The programs they need are often not covered.”

Focus group participants also felt that the Wisconsin behavioral health systems does not adequately meet the behavioral health needs of young people: “Wisconsin’s support seems to not be doing much for children with mental health,” and also suggested that a priority area should be on public education and outreach focused on normalizing MH and SU struggles and information regarding how to access help.

Recommendations for minimizing institutional use among children ranged from utilizing national data and applying best practices and policy recommendations from CMS, SAMHSA and the Administration for Children and Families; adopting the Medicaid benefit early periodic screening, diagnosis and treatment to better fund children’s mental health services; improve evidence-based interventions such as nurse family partnership in-home visiting for high risk infants and their caregivers; increasing reimbursement for parent

“I would just say probably starting these conversations earlier. This type of stuff needs to be talked about in high school around general wellness so that people understand how to keep themselves well but also be able to identify when something is off.”

child interaction therapy and trauma focused cognitive behavioral therapy; and exploring opportunities to use Medicaid to support infant and family/early childhood mental health consultation.

Finally, as many respondents noted, helping children exposed to substances in the home or displaying emotion regulation difficulties requires helping their parents. Often parents who have experienced trauma struggled to provide the best parenting which affects children’s capacity for emotion regulation. Effective consultation can help front-line workers to provide more effective services.

The Elderly

Specialized knowledge is required to support older adults with BH needs. Both respondents and informants raised concerns that the elderly are a growing population that the BH system as a whole is under-prepared to support effectively. This population is marginalized by ageism, which contributes to having their BH needs overlooked. The elderly are also at risk of isolation, as their support networks become smaller over time and challenges in physically accessing services tend to increase with age. Interviewees raised the concern that elderly consumers are placed in inappropriate services precisely because their BH needs are complicated by their developmental needs and related aging concerns. As one respondent noted, “The populations of the elderly, specifically those with dementia related aggression often end up in the state MH facility. This is not where they belong, and it is only due to no appropriate crisis intervention alternatives.” Finally, in addition to the absence of sufficient services to meet the needs of dementia plus emergent BH concerns, individuals managing BH challenges via medications for their entire lives also have to manage the physical toll the medications take on the body over time.

“Often this population accesses services at an outpatient and/or crisis level but needs a service that is equipped to help them navigate services in multiple systems (long term care, medical, mental health, etc.). In many cases, it seems that having a mental health diagnosis may make it more complicated or burdensome for individuals to demonstrate need for care within other systems. Mental health case managers who take on these cases, often find themselves working within systems that require specialized knowledge and training to effectively navigate.”

The possibility of SU challenges among the elderly is overlooked. A number of respondents raised the concerns that SU in the elderly population is often overlooked. Specifically, it was highlighted that there is a tendency to prescribe pain management medications for older adults without looking into underlying behavioral health issues, and without monitoring with the risk of SU disorders in mind.

Youth and elderly with a developmental delay and a BH need face considerable gaps. MH and SU challenges, combined with neuroatypicality, require a tailored behavioral health service approach. However, according to several respondents, few available services can accommodate, or adequately accommodate a child with developmental delays and BH needs or an adult with dementia and BH needs. One interviewee reflected, “So, SU services for kids who might have a slight cognitive delay or on the autism spectrum [but] generally very verbal and no underlying cognitive issues but some social communication issues ... That co-occurring services for that population are really either bad or non-existent.” Developmental delays in the elderly in the form of dementia were also highlighted as a population with BH needs that are frequently mislabeled or overlooked. On the whole, one suggestion brought up frequently was that providers could benefit from, “more training to work with the aging population [on issues such as] hospitalization rates, independence levels, cognitive resilience, employment, etc. Wisconsin is very far behind a number of other states in its ability to serve this population...see Minnesota, Arizona, etc.”

“People with co-occurring intellectual disability- the number of people experiencing this is huge but largely not adequately served. Many times they are overmedicated and not able to self-advocate in the manner that most providers are used to with the general mental health population.”

Individuals Facing Homelessness

Although very limited detail was provided about the challenges consumers who are homeless face in accessing the BH system, this population was in the top five of unique populations identified by survey respondents as falling through the gaps in the system. Many respondents cited that their specific regions lacked affordable housing thus contributing to the rise in homeless consumers. Others highlighted that services that address the BH needs without also addressing basic needs such as food, shelter and safety, will not succeed. As one respondent put it, “ We have had a big increase in the number of [people who are] homeless in [our region] in the past decade, and consequently, need additional support for managing the unique needs that come with trying to help with supporting MH stability for individuals who lack any housing stability.” Others noted that there is prejudice keeping individuals “disabled by MH” from getting into stable housing. Part of the stigma was noted as reflected in a pattern of trying to ‘pass the buck’ on supporting individuals facing homelessness.

“[There needs to be an] acceptance of counties for responsibility to care for the [people who are] homeless and undocumented in their jurisdictions. Too often these people get passed around or denied because of inability to prove where ‘they belong.’”

Consumers with Multiple Marginalized Identities

Finally, although the forced choice options provided in the survey did not allow for many inferences regarding the challenges consumers face at the intersection of marginalized identities, there is sufficient extant data on such patterns for us to offer conjecture based upon the data collected in this gaps analysis.

Elsewhere it has been documented that a disproportionate number of individuals aged 25 and younger facing homelessness identify as LGBTQA (Corliss, Goodenow, Nichols, & Austin, 2011; Grant, Mottet, Tanis, Herman, Harrison, & Keisling, 2010). While other data have suggested that LGBTQA youth facing homelessness are managing more MH and SU challenges than are their cisgender, heterosexual counterparts (Gattis, 2009; 2013; Gattis & Larson, 2016; National Alliance to End Homelessness). Given that LGBTQA individuals were identified by our data as one population particularly unlikely to be adequately served, it is highly likely that LGBTQA consumers facing homelessness are a sub-group particularly vulnerable to gaps in services, especially if they are also a person of color. Many other examples could be cited as well such as an individual who is Native American, deaf, and has a co-occurring intellectual disability. Individuals with multiple unique cultural and health needs are going to have an exceedingly difficult time finding behavioral health services that are culturally appropriate for them.

Barriers to Accessing the Behavioral Health System

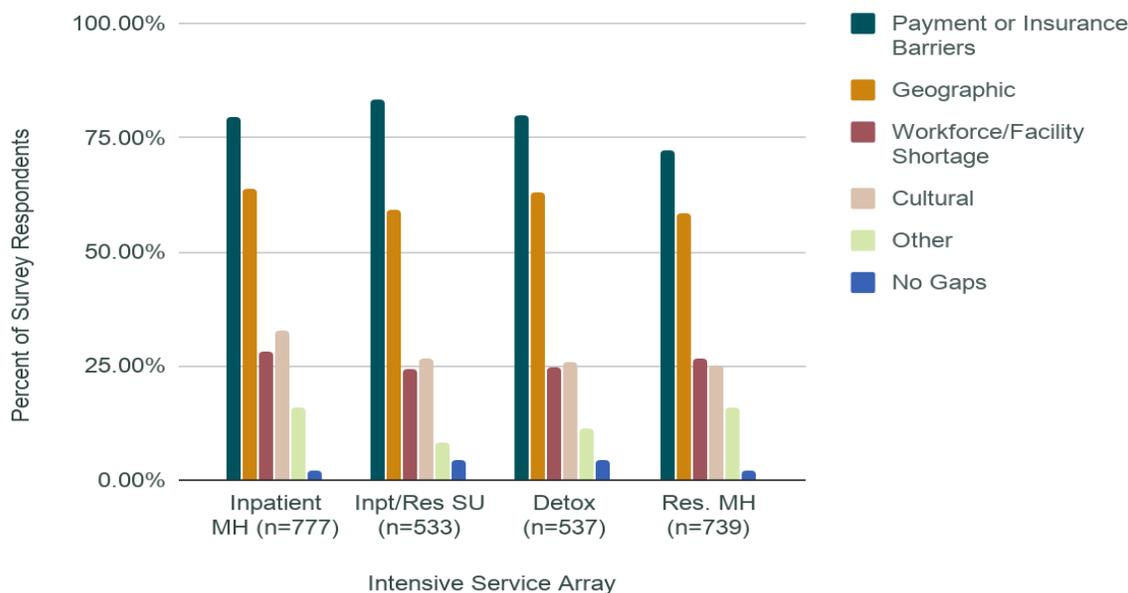
The lack of certain services and providers result in service gaps amplified by policy, systems and environmental barriers to accessing BH care. This section focuses on the specific barriers to accessing each service array component identified by survey respondents.

Accessibility refers to how easy or difficult it is for consumers to use available services when they do exist. In the interview protocol, key informants were asked to speak to what gaps and barriers they saw in the system without prompts regarding specific service array components. In the provider survey, however, respondents were asked to indicate which of the following barriers, if any, leads to gaps in various service array components. The list of potential barriers to choose from included: geography, payment and/or insurance barriers, cultural barriers and workforce/facility shortages. Respondents were also given the option to either indicate that they did not see any barriers to a particular service or to write in a barrier not listed.

The same questions were presented for SU and MH services in separate sections of the survey that appeared, based on the area(s) of expertise reported by the respondent. In other words, if a provider indicated at the beginning of the survey that they could only speak to the MH services, they were only prompted to answer questions regarding inpatient MH, residential MH, crisis, and outpatient MH. If they indicated expertise over both arms of the system, they were prompted to answer questions regarding both MH and SU services. For each barrier a respondent selected (e.g. payment and geographic) and for each service array component (e.g. Inpatient MH), they were asked to indicate which specific payment or geographic barriers were relevant for that service array component.

Results show that the response rate for barriers, relative to each other, is consistent across services (see Figures 10 & 11). However, the absolute frequency with which a barrier was identified varied. For each of the four components of the intensive service array (see Figure 10), payment/insurance was selected *most frequently*, followed by geographic barriers. For both MH and SU inpatient and residential services, cultural barriers were the next most frequently identified barrier, followed by workforce/facility shortage. The third most frequently identified barrier for detox was a virtual tie between workforce/facility shortage, and cultural barriers and finally, the least frequently identified barrier was *other*.

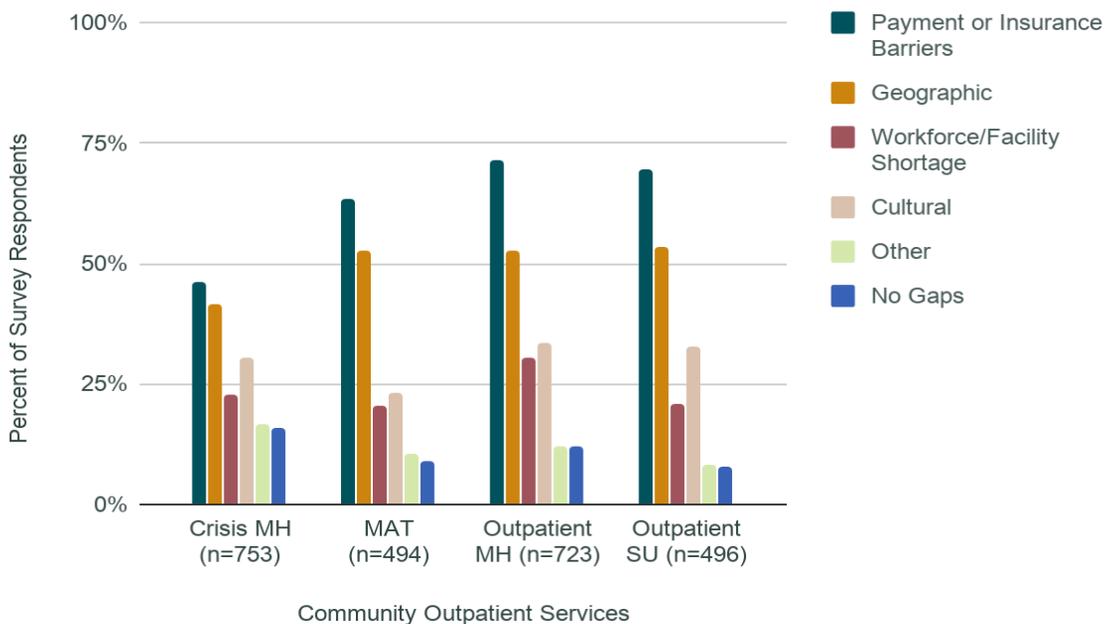
Figure 10. Perceived Barriers to Intensive Service Array



Similarly, patterns of barriers were very similar across **community outpatient** service array components (see Figure 11). For each of the four components, payment/insurance was selected *most frequently*, followed by geographic barriers. Cultural barriers ranked third most frequently, followed by workforce/facility shortage. *Other* was the most infrequently selected barrier. Although payment and insurance barriers were the most frequently named barrier for each service, 75% of respondents selected this as a barrier for outpatient MH services, whereas less than 50% felt it was a barrier to receiving crisis services.

Of note, respondents were least likely to identify cultural barriers to MAT, and about equally likely to report it for MH crisis, and outpatient MH services, and outpatient SU services. Additionally, survey respondents made the most use of the “other” write-in option when identifying barriers to MH Crisis services. The primary theme in the “other” category was that the practice of involving law enforcement in behavioral health crises discourages consumers from seeking this type of support when they acutely need it, as does stigma about experiencing acute MH crisis in general.

Figure 11. Perceived Barriers to Outpatient, Community Services



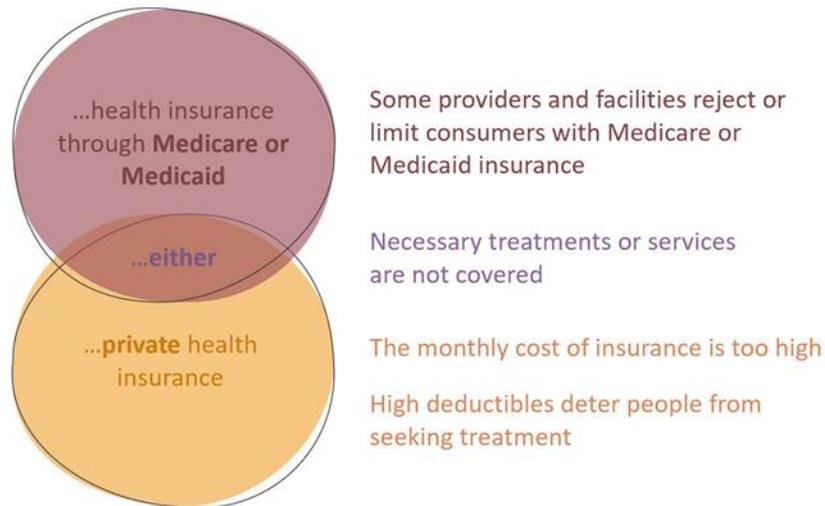
Payment, Insurance, and Eligibility Barriers

Deciding who pays for services and which services are covered is challenging in a society without universal healthcare. Eligibility requirements and insurance limitations act as barriers to services by limiting or restricting what kinds of care individuals can receive. These barriers are shaped largely by administrative processes, which operate in individual organizations, public and private insurance agencies, state regulatory bodies, and state behavioral health agencies. Attention to gatekeeping mechanisms is critical to ensuring that the right resources are reaching all individuals with behavioral health needs in Wisconsin.

Each survey respondent that indicated insurance and cost as a relevant barrier then received a follow up question asking them to indicate what *type* of insurance or payment barriers were relevant. Survey respondents were most likely to indicate that provider and facility MA patient quotas are a barrier to consumers. The most frequently noted barriers for consumers on private insurance focused on the prohibitive cost of insurance. Finally, the next most commonly mentioned barrier, for both public and private insurance, was coverage limitations.

See the technical report of the survey results for a list of the frequency of responses to each type of payment and insurance barrier. In the following section, themes that emerged in interviews and focus groups related to these barriers are described. The themes in payment and insurance barriers can be broken into two areas of focus: financial barriers and barriers associated with insurance policies regarding eligibility.

Survey respondents were most likely to identify the following **insurance and payment barriers** for consumers with...



Financial Barriers

Emphasizing their importance, financial barriers were important to individuals in a national survey also. When asked about the reasons for not seeking mental health treatment, more people (41%) described the cost of treatment as a barrier than any other reason (NSDUH, 2017). The fifth-ranked reason for not seeking mental health treatment was the lack of adequate insurance coverage at 15% of respondents. For those seeking substance use treatment, 31% described the cost of treatment as a barrier which was the second-ranked barrier and 11% said the lack of adequate insurance coverage was a barrier which ranked eighth.

Insurance limits on coverage for inpatient and residential services. As discussed in the section on gaps in residential and inpatient services, one of the most commonly cited services that was needed but not generally covered by Medicaid was inpatient and residential MH and SUD treatment. Some believed the only route to residential care was via a Chapter 51 commitment. The experience of several providers was that, “Residential MH services are extremely scarce in this state, and where they are available, they are reserved for people on Chapter 51 commitment.” Similarly, it was noted that, “For youth, residential services often require court involvement or a court order.” Additionally, the difficulty of getting insurance to authorize this level of care was a frustration commonly voiced in the survey. Through the survey data, providers shared that they often disagreed with county decisions regarding eligibility and length of stay necessary for stabilization. A number of respondents conveyed the belief that “hospitals are not motivated to keep people as long as they need to be kept.”

Additionally, in response to the survey question regarding insurance barriers to accessing inpatient and residential SU services, it was highlighted that “Medicare often doesn't pay unless [the worker has a] MSW. Medicaid pays for residential ONLY through CCS. Medicaid needs to pay an appropriate daily rate to all residential facilities who are state-licensed.” Unfortunately, this is a disincentive to providing these services. “MA doesn't cover residential in a way that is feasible for residential providers,” which suggests that this policy may be directly contributing to the severe facility shortages noted by informants and respondents that was discussed in the section on workforce and facilities gaps.

“Extremely brief times allowed for people in IMD’s. Also, the habit of IMD’s stopping all meds and discharging people without adequate time to titrate up and absorb the new medications and achieve real stability creating havoc in the community and bouncing between hospitals for members.”

Private sector insurance policies resist covering more intensive needs. Private insurers also have a role to play in ensuring all people in Wisconsin have access to behavioral health care. Many respondents identified a difference between de jure and de facto parity in coverage for behavioral health services. One interviewee explained, “Commercial plans do not understand and are not equipped to provide the kind of coverage it takes for somebody with a severe mental illness or a severe SU disorder to get the level of services that they need. Relapse is a part of SU disorder. Becoming symptomatic can often be a years-long process for people who have serious mental illness. So, these things need to be covered if people are going to be able to get services.” Some interviewees also pointed to a challenging dynamic where private insurance providers push out consumers with more intensive needs into public services, exacerbating the strain on an under-funded system that has a mandate to treat all citizens.

“The private sector hasn’t been keeping up with the need for higher end placements for behavioral health kids. I know there’s quite a few counties in the area, in our area that are shipping youths out of state. There’s ten different reasons why we couldn’t want to do that. Their back’s against the wall because the providers we have here won’t admit them or won’t take them,”

Substance-specific funding streams may serve as barriers to care. The growth in awareness of opioid addiction has led to the proliferation of targeted opioid addiction treatment grants from the federal government. Conversely, individuals receiving MAT for opioid use disorders may not be able to access some services, such as residential treatment and sober housing, due to abstinence-only treatment models. Additionally, Individuals with other SU service needs, or who are addicted to multiple substances, are faced with sparser treatment options. Finally, substance-specific funding streams create challenges for individuals abusing multiple substances to get the treatment they need.

Costs to consumers, including co-pays, are prohibitive. Survey respondents emphasized that the high cost of service is a barrier to receiving treatment. Inability to pay is particularly troublesome among consumers beginning recovery, who may be well-enough to sustain employment but no longer qualify for public aid. This may be a barrier even for individuals that ostensibly qualify as “middle class.” Because of limits on coverage for inpatient and residential SU services, these are some of the most expensive services for consumers to secure. As a result, access is limited to those who can pay out of pocket, or who live in counties with the budget to cover costs. Additionally, it was noted that when consumers don’t pay their co-pays, the provider must send them to collections and frequently wind up shouldering the costs themselves.

“People don’t get insurance because it costs too much, and they don’t make enough money at their job. And to get state insurance you are to be in their guidelines which means you can’t afford to live. I feel if insurance was more available and didn’t cost so much money and offered all the services needed, we’d have more people seeking treatment instead of continuing down the road of addiction. A lot of people’s addiction start with their mental health and not being able to get services for that. Again it boils down to insurance being available to all the citizens of Wisconsin.”

The Impacts of Poor Reimbursement Rates on Workforce Capacity

The ability of the existing workforce to adequately meet the needs of the consumers is in part a reflection of the adequacy of preparation the workforce received prior to entering the field. Workforce capacity and service adequacy are also largely a reflection of the conditions of the work as well. Even the most well-prepared individual may place limits on how many clients they see, based on the other administrative and business obligations they face.

Low reimbursement rates make the business of providing care unsustainable.

The number one sentiment regarding the cause of gaps in the system was the underfunded nature of services. From people working in Milwaukee to rural Wisconsin, in both MH and SU

“MA reimbursement rates are too low, if as a provider I can take a private insurance client that I get paid more for vs. MA, with my own personal expenses I choose the higher reimbursement. Everybody does when possible; MA clients also have a ridiculous amount of paperwork to get treatment, be pre-authed for treatment, only certain services, only certain amounts of service per day.”

service fields, almost every interviewee named inadequate reimbursement rates as a cause of gaps in service. One man described the crisis of funding for the providers he consulted with, recounting, “Our Medicaid reimbursement was so low that a few or maybe all of those clinics over the... northern part of the state were barely staying open, because their Medicaid [and Medicare] percentages were roughly 70%, reflecting the poverty in the rural areas and the aging of the population.” Because of the poor reimbursement rate, behavioral health services end up draining resources from the organizations that provide them. Even when organizations serving populations on medical assistance are able to balance their

budgets through grants or county-level funding, they are ultimately strapped for resources. This has trickle-down effects on their ability to hire, train, and retain providers.

Quotas for consumers on Medicaid are a barrier to finding treatment options. A frequent concern was that though providers and facilities exist, and may even have openings, they can't afford to take clients on Medicaid because reimbursement rates are so low. One person working in MH services in rural Wisconsin reported, "[It] is very difficult for these individuals [providers] to earn what they think they should earn if they need to see medical assistance patients as part of their mix. We have lost providers to private practice for that reason, because in a private practice setting, they can make the rules about only taking commercial insurance patients."

Time spent completing non-reimbursable paperwork limits provider capacity to accept Medicaid clients.

Medicaid funding requires more administrative paperwork than most funding sources. Documentation is required for consumer eligibility, pre-authorization, provider qualifications, and billing. Time spent completing the paperwork is not paid for by Medicaid which means providers spend a lot of non-billable time on administrative tasks. As a result, organizations sometimes limit staff working with Medicaid clients and/or limit the number of Medicaid clients they accept in order to stay financially sustainable.

"Low reimbursement rates/paperwork/time to reimbursement. Reimbursement for mental health services have been decreasing for 15 years. I can't afford to accept insurance reimbursement as an individual provider as too much paperwork, high deductibles, need for primary care referrals thus reduced privacy, late payments!"

Poor reimbursement relative to Minnesota creates workforce gaps in bordering areas.

Many interviewees specifically highlighted that Wisconsin's Medicaid reimbursement rates are among the lowest in the nation and are regionally low in comparison to our neighbors in Minnesota, making it difficult to recruit providers. One survey respondent wrote: "The number of providers is insufficient to meet the needs of our rural community. Because we are a border town, it is difficult/impossible to keep behavioral health providers in our region of the state, as they can easily make nearly double by simply driving 10-20 minutes to work in Minnesota where reimbursement rates, and thus salaries are significantly higher."

"The Medicaid provider portal is extremely user-unfriendly for solo practitioners who do their own billing. It is not intuitive, needlessly complicated, and seems to be designed to discourage its use by providers. If this was fixed and I would reliably be paid for straight Medicaid, I would see more Medicaid clients (I'm a psychologist in solo practice). As it is, I really can only see Badgercare or Medicaid clients who are on one of the HMO plans because I can use their portals which are very user-friendly."

Eligibility and Access Barriers

The general complexity of the behavioral health system and the details of insurance coverage for services were both named as barriers to accessing care. Key informants also noted challenges in getting people who need support in the door. One person working in both the MH and SU field observed, “[It’s] difficult sometimes to know what your coverage is, because insurance is hard to navigate no matter what. And if you’re struggling with mental illness, it’s even harder sometimes to navigate what services you have and don’t have.” Several respondents felt that the public at large, and even some primary care providers, don’t have a clear understanding of what public behavioral health services are available, and to whom. Unlike for complex medical conditions like cancer, private insurance doesn’t provide patient navigators to help people with similarly complex behavioral health needs.

Eligibility determination processes may unnecessarily delay care, risking relapse or condition escalation.

The process of eligibility determination itself is a barrier to care, according to many of the individuals interviewed. In this context, eligibility includes determining what services are covered through a person’s insurance as well as functional assessments and screenings. Both the complexity of these processes and the amount of time it takes to get people approved for care leads to patient drop-off. Key informants highlighted that in the case of SU treatment, delaying care for even a few days could mean the difference between relapse and recovery.

“I think it needs to be re-evaluated to where a client don’t have to go to so many appointments to get any medication. Just speed up the process.”

The practice of delaying treatment for consumers with “moderate need” may increase the need for more intensive services. Interviewees from around Wisconsin also noted that some individuals aren’t able to access services until their symptoms are acute enough to qualify them for a particular intervention. Several providers described that clients can be screened out of services when their symptoms are less acute, though treatment at that point would be more effective. This pattern puts people in situations where they have to get worse before they can get better, ultimately costing the system more money and impacting the well-being of affected individuals.

“[Sometimes] we have to wait so long [for patients] to be eligible for services in our system that it’s kind of, you have to backtrack and mend things and do some pretty extreme interventions.”

Current triage practices with crisis services frustrate providers trying to connect consumers to immediate treatment. Eligibility barriers for accessing MH crisis services also came up frequently. Although crisis services don’t have a formal eligibility process, some felt that “[crisis] services are often denied to people who cannot prove their crisis is life or death.” One respondent wrote: “The system fails those in acute crisis. Unfortunately, a person in a MH crisis must hurt themselves or somebody else before the area crisis system will connect to the MH system.”

Though this concern surfaced for county-level behavioral health in general, some interviewees also highlighted this dynamic in the context of involuntary admission and some block grant requirements. One man working in rural Wisconsin across MH and SU systems noted, “You have to be pretty sick to be eligible for care in the involuntary system. In many cases, there is no service available until you come in with the police.” However, police transport entails being handcuffed and riding in the back of a police car which likely contributes to further destabilizing the individual in crisis and thus serves as a barrier to prevention and early intervention efforts across the state (Treatment Advocacy Center, 2019).

“[Do] we really need to waste several days to figure out their eligibility in regard to insurance and all that stuff? Why can’t we just start treating them and then work out the details as we go?”

Assessment tools can be excessive and imprecise leading to delays in care or no care at all. Beyond the time and complexity of eligibility processes, interviewees also questioned the fundamental effectiveness of screenings and assessments. One individual working in the MH system argued, “We know when kids are struggling, we know when families are struggling, and most of these individuals have been assessed to death. We have tons of assessment on them, and we’re really not changing outcomes.” This suggests that rather than connecting people with the services they need these administrative processes may be a burden and a barrier to needed care for individuals and families. This was reported as an especially acute problem in cases where the assessment tools screen out individuals that providers believe are eligible for service. As an example of this, one interviewee recounted how a Hmong individual they were working with was deemed ineligible for a program: “I knew what their issues were. And I knew that they qualified for certain specific programming. But when we sent them for a functional screen, because of the cultural differences and probably because of some implicit bias on the part of both the consumer and the screener, it didn’t work out.” A survey respondent identifying barriers to inpatient services pointed out, there is a sense that inpatient “criteria excludes the neediest; [and/or there is] incorrect application of the criteria by workers in the systems; burnout of the workers in the systems.”

Many providers report difficulty getting crisis staff to conduct an assessment. Several respondents spoke of challenges in using the crisis hotline - talking to answering machines more often than they liked: “Challenging to access crisis staff (get answering machines at times) - unwillingness to assess cases in our ED [emergency department].” Additionally, some conveyed the belief that crisis workers avoid engaging with calls coming from skilled nursing facilities (SNF), believing that crisis staff feel the staff at the SNF should take care of the person.

Medicaid eligibility ends as clients achieve financial stability, increasing the chances of exit from needed

care. According to providers, the cost of insurance, co-pays, and prescriptions is a barrier for many. It is common for a consumer who becomes employed to be rewarded by being dropped from Medicaid, but still not make enough money to cover marketplace insurance. This challenge is especially acute when trying to maintain a MAT

“BadgerCare has been great at allowing consumers to get treatment. The problem becomes they get a job and then lose BadgerCare. We should be glad they are working but then they are unable to afford their new private insurance. A lot of the jobs do not pay well, and they can’t afford the co-pays or deductible. So many decide not to work to remain under employed. This ends up being a huge burden on taxpayers of the State.”

schedule: “[Once] they get employed and no longer qualify for MA, they may not be able to afford insurance so there is a gap in treatment, especially if Vivitrol is used which costs \$1000 per month per shot.” Others noted that the threshold of recovery for some insurance policies becomes a barrier to success if placed too soon in the process.

Although there is a logic to reserving social welfare benefits for the most impoverished, with wage stagnation in the United States, too many consumers with jobs are still unable to afford the low-deductible health care premiums, the co-pays, or the high-deductibles associated with the affordable premium plans. So, they must either forgo gainful employment or their health care.

The policy of kicking consumers off Medicaid when they are taken into custody can exacerbate problems.

As some interviewees highlighted, Wisconsin’s prisons and jails are some of the largest behavioral health care providers in the state. These behavioral health services, where they do exist, were characterized as being inadequate. Losing Medicaid when incarcerated means that consumers have no treatment options upon community re-entry and have to start from square one becoming eligible for Medicaid or other insurance.

“Funding sources exist in silos, such as incarcerated individuals are unable to continue treatment, so punishment becomes treatment, which results in more trauma. Why not change the Medicaid rules to allow incarcerated individuals who have Huber rights to continue with treatment while serving their sentence? Ultimately this would save money and prevent recidivism as inmates can be reintegrated into the community with a more solid sense of self and confidence that they can stay sober and maintain the progress they’re made in their MH.”

Admissions policies for detox will not allow in many who could benefit from this kind of support. The most frequently mentioned category of barrier for detox services was eligibility and admissions policies. Survey respondents highlighted restrictions on the type of substances allowed for admission for detox, consumer bans based upon recidivism, and other blanket statements that, “Many hospitals will no longer admit for detox, or only under what is considered medically necessary, sending addicted clients home with medications they often abuse and not enough supports to help them take the next steps.”

Missing appointment policies are too strict and create barriers.

A commonly voiced concern regarded policies governing how private outpatient providers responded to missed appointments. One survey respondent wrote: “Many of the providers in my area have policies where if you miss your appointment

“Ridiculous cancellation policies which charge you if you cancel in less than 24-48 hours often deters this group from seeking treatment. I have a daughter who stopped going because she would have to work late and kept getting charged \$50 for canceling in the morning for an afternoon appointment then the facility refused to let her see the therapist until the fees were paid. That’s a huge barrier!!”

you are placed on the waiting list for 60 days before being allowed to make another appointment.” Others noted that there are sometimes fees for missing appointments that serve as a barrier to services.

Decisions on levels of care are not made by the treatment provider, which can be a barrier to recovery.

In the survey, providers expressed that care decisions are

“[Just] because [insurance starts to] notice that people start having negative UA’s, [they stop covering treatment]. Yes, that’s a great thing! That means the treatment is working but then they want to say they don’t need [treatment] anymore which is absurd. This is when they need it most. Long term recovery is important! Recovery is life-long. It’s a process and they seem to not understand that.”

primarily made based upon some external criteria rather than a focus on recovery. As a result, inappropriate services may be authorized, and later authorizations may be delayed: “[Private] Insurance companies have more authority over the level of care needed than the medical professionals who refer. Sometimes a youth who was unable to access outpatient care when needed has reached a level of severity where inpatient is recommended; however, the insurance will deny that access because outpatient was not completed.” Others noted this challenge with getting residential MH care authorized by the county: “No long-term residential care program for MH, the county limits how many clients can receive this care, county makes decisions on what clients need vs. following the advice of providers.”

Parental involvement and consent can be a barrier for youth to access services. This barrier is inferred by the following recommendation that was listed as a top priority for a survey respondent: “Extend availability of MH and SU services to older teens even if their parents don't make the effort to access services.” This policy likely contributes to the gap in services for transition-aged youth which were identified by survey respondents as the second most frequently mentioned population with a service gap.

Stakeholder Recommendations: Address Eligibility, Insurance, and Cost Barriers

Many barriers were described in this area, but the cost and insurance coverage barriers were typically prioritized by respondents. Most of the recommendations for change reflect this by focusing on increasing funding, reimbursement rates, and coverage. Some emphasis was also given to increasing access to services by further educating providers and consumers on the behavioral health system.

Educate the public and service providers on what services are available in the BH system.

There were clear requests for the development of websites or regular mailings and listservs to

spread awareness about how the behavioral health system functions. As one provider put it in the survey, “More availability of services. A clear list of services available. I am a MH provider working in medical hospitals with medical patients. It is very hard to identify the services that are available out there unless they are systems or people I have had personal contact with. It is especially difficult to identify substance abuse treatment.” Another pointed out the need for educational materials to be translated into various languages: “Not enough advertisement in various languages. People are not aware of services in their area.” Additionally, it was suggested that the gaps in knowledge regarding the system are leading to intergenerational dependence on the system.

“More resources to early intervention, adults in need of services and falling through the gaps in services were once children in need of services. The earlier the prevention/intervention, the [fewer] adults and essentially children of adults in need of services that we will see in crisis.”

Invest in system navigation resources. Consumers may need support in securing the appropriate services in a timely manner. One suggestion was to create specific roles for this purpose: “Provide funding for ‘system navigators’ or peer specialists to help people seeking treatment to access the services they need. For example, to apply to CCS, there are multiple forms and a psychiatrist signature required and some people in the throes of addiction do not have the capacity to navigate it all.”

Bolster state enforcement of health insurance coverage parity for behavioral health services. State law explicitly mandates parity in coverage between behavioral health and general health. Accordingly, some interviewees suggested increasing state enforcement of this law. Another key informant recognizing the limited capacity of the Office of the Commissioner of Insurance, proposed allocating resources to ensure staff has the time to follow through on parity investigations.

Expand income limit eligibility for Medicaid. This recommendation was made specifically to address the concern that consumers managing addiction get kicked off of their benefits because they enter into a liminal zone of being able to maintain employment, but unable to afford the marketplace or private insurance coverage. Specifically, respondents suggest the State “extend Medicaid to continue providing coverage for treatment and medications for a longer period of time (3-6 months) after someone exceeds the income limitations. Most new jobs do not provide insurance for several months, so many people suddenly find that,

“Allow more of an overlap in Medicaid eligibility when people begin working and earning too much to qualify. I’ve seen several situations where clients relapsed because they were on medication-assisted treatment with their Medicaid and then they were no longer eligible and had to pay out of pocket (\$18/day). They couldn’t afford it, so [they] chose to rapidly detox off MAT and then relapsed. Private insurance offered by employers is often more than people can afford and even if they get help through the Exchange and deductibles are so high, they can’t continue MAT on that insurance.”

when they are finally stable enough to hold down a job, they suddenly lose their medication and/or providers, and cannot yet afford to pay for them out of pocket or buy private insurance.”

Increase reimbursement rates and expand the range of reimbursable facilities. In order to more effectively utilize the existing workforce and facilities, one key and urgent priority was to make it financially feasible to provide care for consumers on Medicaid. One survey respondent wrote: “Include satellite locations in reimbursement rates for the same facility hospital. We can't get the same MA rate of reimbursement for children's psychotherapy and psychological assessments under MA in our satellite locations as the hospital, so we cannot serve clients in need here.”

Consider expanding fully-funded programming options, especially in rural areas. Concerns about funding are felt throughout the state but are especially pronounced in rural areas. Several respondents report historically inadequate funding and resources for rural counties. Comprehensive Community Services (CCS), which has been implemented by 66 counties and three tribes in Wisconsin, was celebrated both because of the increase in resources it entails and because of its more holistic approach to care. One person emphasized that CCS has “been a game-changer for a lot of counties. Again, I guess maybe administratively it's burdensome. But at the end of the day, it just brings in so much money and by extension, the money brings in providers.” A person working across the MH and SU field argued, “[The] 100% reimbursement for the CCS program has had a huge impact. So, priority would be, make sure that that funding stays intact. ... I would say that's a huge priority because we are providing ... quality, community-based services.” Others expressed the belief that services like Community Support Programs (CSP) would also benefit from full funding. One person noted that unlike CCS, CSP's rates are “extremely low.” As a result, she says, “[the] county not only has to pay the non-federal share of that program, but they have to kick in even more money because the rate that you get paid is not sustainable.”

While utilization of specific practices (CCS) and newer policies on reimbursement rates was mentioned, several providers simply advocated for a higher allocation of state funds for these under-resourced areas. Several respondents also made connections between low funding and statewide struggles to attract and retain behavioral health providers. One interviewee asserted that “I think that if we can provide more funding ... for the state to provide more funding to rural areas, I think that that will attract more providers to it so that they can actually want to stay.”

Equitably reduce costs for consumers. Focus group discussions regarding ways to reduce costs for consumers focused on insurance adjustments to accommodate all people seeking MH services and not only those who can afford it. Specifically, insurance adjustments in the form of providing a sliding scale fee approach to co-pays: “Making service more equitable in the sense of being able to actually engage with multiple different identities but also in the sense of more people kind of having scale-type ways of payment.”

Geographic and Physical Access Barriers

A feature of gaps in services is that available services can be challenging to access. Whether rural or urban, reliable and affordable public transportation is an issue as are wait times to get in to see the few providers that are in an area. As one respondent put it, “Even the bus is very expensive. When you’re in your fresh recovery, having to choose between going to a doctor’s appointment and eating... Yeah, those are challenges in our world.” Survey respondents who indicated that geographic barriers were contributing to gaps in service for a particular component of the array (e.g. outpatient MH) were given a follow up question regarding specific types of geographic barriers as well as the opportunity to write in one that wasn’t offered. Forced choice options included: *travel to services is difficult because of weather or road conditions, services too far away, clients lack personal transportation, non-emergency medical transport is unreliable, lack of any public transportation, and public transportation is unreliable or inconvenient to service locations.*

“So, you could be in the middle of Milwaukee but still have an access issue. ... There’s access challenges in urban areas and there’s access challenges in rural areas. They’re just different.”

In the survey, the most commonly reported **geographic barriers** to access for behavioral health services, in order of frequency, were...

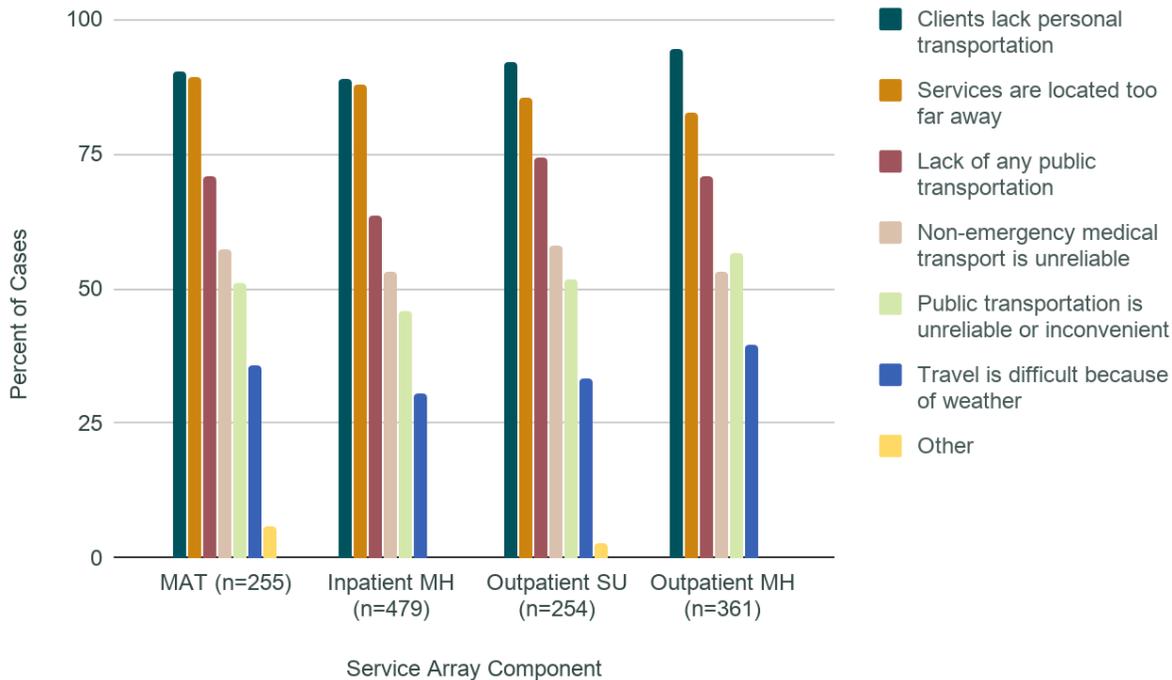
1. Clients lack personal transportation*
2. Services are too far away
3. Lack of public transportation

“Clients lack personal transportation” was the most frequently listed geographic barrier, and “services too far away,” was the second most frequent barrier for all of the service array components aside from residential services. For residential services, the order

*Ranks 1 and 2 are swapped for *residential* mental health and substance use services

of frequency was flipped with the most frequent barrier for both MH and SU being, “services are too far away” followed by, “clients lack personal transportation.” “Lack of public transportation,” held the third most frequent slot for every component, whereas “Non-emergency medical transport is unreliable,” was fourth for all services except for crisis/emergency MH and outpatient MH. The fourth most frequent for crisis/emergency MH and outpatient MH was, “Public transportation is unreliable or inconvenient to service locations.” Across service array components, “difficult road conditions” was the least frequently selected barrier. See Figure 12 for a graph of how each geographic barrier was ranked for four of the service array components.

Figure 12. Frequency of Barriers Associated with Geography



Where services are few and far between, access is a pressing issue. The lack of services and providers across the state is more than just an availability issue. It also affects the accessibility of services that *are* available. For one, residents in need of behavioral health services end up having to travel long distances to receive care. In interviews, this issue of distance and transportation was described as being especially acute in rural and small-town areas. In part, this is tied to the inherently low population density of these areas. People live further apart, but they also tend to live further from services on average compared to residents in more densely populated areas. One person noted, “[In] rural areas, there will be one provider for a service. ...Transportation becomes a problem, trying to get to the provider. They are located in the middle of the county or at one end or another of a county, and so transportation becomes a huge barrier to getting access.”

Distance and lack of reliable transportation widens gaps in treatment. Ultimately, distance from services means more than just the annoyance of a long car ride, or one or two missed appointments. For individuals without a car - not a small proportion of individuals on public assistance - that distance

“If you live an hour away, two hours away, with no reliable transportation, no matter how motivated you are to be sober or to recover from addiction, just no one, no matter how motivated, can get themselves that far without transportation. Folks tend to sometimes burn a lot of bridges when they’re struggling with addiction, so they don’t maybe have a lot of natural support who want to give them rides, so the transportation becomes a pretty big barrier.”

becomes a major health concern. Interviewees consistently mentioned stories of patients travelling hours, sometimes upwards of four or five, to access needed care. The distance is compounded for people who have multiple behavioral health needs, because of the lack of wraparound or comprehensive care centers. When transportation to one place for services is difficult, finding a way to get to multiple clinics or care centers is even harder. Furthermore, it was noted that people facing SU disorders often wear through their informal support networks - the friends, family, and community members who might otherwise be able to give them a ride. Lack of personal transportation, public transportation, and reliable rides from others combines with long distances to put individuals with the least resources at a further disadvantage when it comes to accessing care.

Neither Medical Transit nor public transportation are reliable in closing the geographic gaps. Wisconsin's non-emergency medical transit provider for individuals on public assistance, Medial Transport Management (MTM), came up in interviews as one important piece of the transportation issue. In theory, MTM is meant to close the transportation gap. However, most interviewees mentioned it only to highlight the ways in which it fails to live up to that purpose. One person working in the MH system reported, "MTM... has been extremely unreliable, and we have heard from so many consumers about being forgotten, being picked up late for their appointment, and that doesn't really work." Another person recounted, "We have a lot of consumers that live one to two miles away from the counseling agency. They are not able to walk it. Especially in the winter it's not safe for them to walk it. We can't get [MTM] to pick them up and take them to that appointment because it's not worth their time." There is a clear need for the service, but many of the interviewees felt that the current system isn't meeting that need. This frustration with MTM highlights an opportunity to improve non-emergency medical transit or consider more innovative ways to reduce the burden of distance for consumers.

Rural and small-town Wisconsinites face a lack of public, or even private, transit options, like buses and taxis. But even in urban centers like Milwaukee and Madison, where public transit does exist, transportation can still be a barrier to care. Low income individuals, the elderly, and those living in neighborhoods with less access to reliable public transit were reported to be the most impacted. A person working across rural and urban areas noted, "Often in urban communities, there's the issue that not everything is on a bus line or families don't feel comfortable taking the bus line to get from point A to point B. And if they don't have a car, it really is limiting."

Waitlists across the service array are an issue everywhere in the state. Even when a person can get to the service center, they may not be able to receive care for a month or more because of long waitlists for services. This barrier is an extension of workforce and facility shortages, which lead to a mismatch between the number of people needing care and providers' capacity to meet that need. Another interviewee noted how organizational policies around no-shows can push out low-income individuals without reliable transit.

"Availability – no room in programs. There needs to be easier access to getting help one needs WHEN ONE NEEDS IT. Waiting for weeks for treatment is not acceptable. We lose them. They go back to using. We need to be able to offer treatment when their motivation level is high."

Navigating this tension on an organizational level is an important facet of the conversation around access to care.

Several interviewees with experience in urban areas highlighted how the apparent abundance of services in cities may not actually increase accessibility, because of the greater number of individuals in need of services. One person working across urban and rural areas lamented, “[The] services that we do have are overwhelmed, which is why some people have to wait for services. And sometimes that can really crush someone who has decided to seek service. ...And again, if you showed up with a broken leg, they would take care of you. They wouldn't say, come back in three months.”

Providers are having to move to more intensive (and expensive) treatment options because of the absence of reliable transportation. In reference to MH crisis services, a number of informants and respondents shared the concern that consumers are escalated into more intensive treatment options because of geographic barriers to services. Specifically, a number of providers noted that without ready access to existing services, it is not uncommon for counties to escalate the screening of a consumer into the need for more intensive services in order to get the consumer access to services at all.

“We frequently have fold who are willing to seek voluntary hospitalization as opposed to us having to do an emergency detention, but many times, we’re having to move to that higher level or restriction due to the lack of transportation available.”

Stakeholder Recommendations: Address Transportation Barriers

Geographic accessibility of services was one of the most prominent gaps highlighted in interviews - from transportation issues to regional service array. Many ideas about how to ensure more people in Wisconsin are able to get to the services they need were voiced and are described below.

Co-locate and regionalize services to reduce the amount of transportation needed. One common suggestion, referenced previously, was to invest in the co-location of behavioral health services. For some patients, this could also involve a wraparound support approach. One man asked, “Why not have a wraparound center ... so people don't have to worry about transportation so much?” Building on this suggestion, many interviewees highlighted a need to establish regionalized behavioral health triage centers, including the adaptation of a hub-and-spoke model (see graphic below for a brief explanation of the hub and spoke model being utilized to address SUD needs). This approach was seen as a key solution to the lack of services in rural Wisconsin. One respondent working in rural Wisconsin argued, “[Regional] crisis centers and regional psychiatric emergency rooms, coupled with places like our crisis resource center, would be a big improvement.” However, as one person cautioned, “[How] you develop a hub and spoke for those may be different based on the incidence of the illness. I can certainly see a different regionalization for CCS than for AODA services than for crisis services, because how people seek those services is different.” As the state

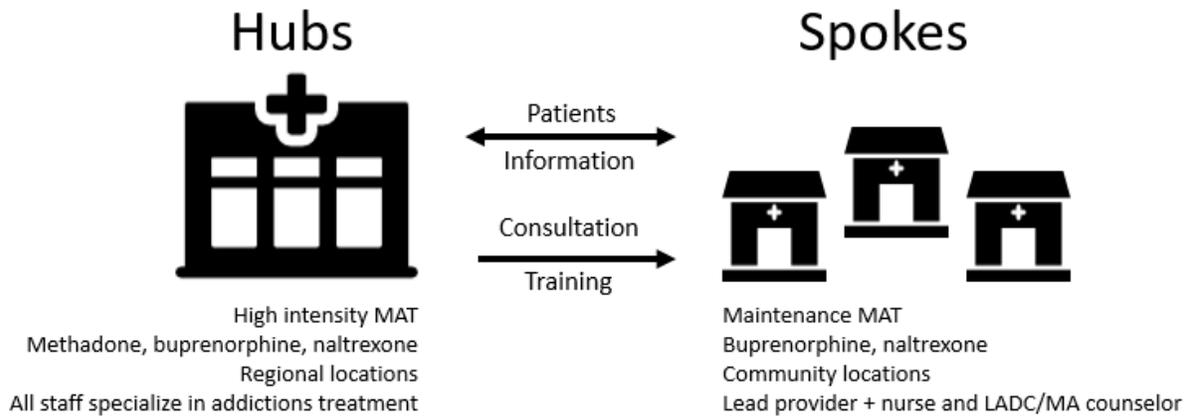


Image source: <https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>

looks into instituting more regionalized care, there could be additional conversations about the strategic distribution of various kinds of services.

Invest in a wider array of transportation options. One suggestion highlighted was to return to a non-emergency transport system “to the counties” and another was to upgrade to the “Use [of] a system like Uber or Lyft (app-based) to coordinate non-emergency medical transport. This is being done successfully in Atlanta, GA. It allows clients to see a picture of who is picking them up, what their car looks like, and uses GPS technology to see how far away [their ride is]. This [would] reduce a lot of anxiety as many of our clients have a significant amount of fear over who will be picking them up.” The state could also help cover patients’ transportation costs in other ways. One respondent highlighted that in the CCS model, case managers are able to pick up consumers to transport them to services. For urban contexts, where public transit is more available, an interviewee suggested expanding reimbursement “so that you're able to give the money for the two bus passes that it took for a family to arrive, or you're able to reimburse for the taxi ride they had to take to get here and there.”

Renegotiate the contract for NEMT with MTM. Currently, individuals on Medical Assistance can request non-emergency medical transportation (NEMT) to appointments. However, interviewees described the current NEMT provision as being inadequate to the needs of the people with whom they worked. One way to resolve this gap suggested was to renegotiate the contract with the NEMT provider, MTM. This was suggested by a person working in a rural area of the state, who argued, “I think there could be some pressure put on MTM to actually figure out how they're going to best serve our population up here. ... Wisconsin has a contract with them, figure it out. There's no reason that someone cannot get a ride to an appointment in their own town. I think that there could be some discussion there.” Finally, in the negotiation process, key informants emphasized the importance of ensuring MTM will transport children in order to accommodate the needs of consumers who are also caregivers and may not be able to either arrange or pay for childcare to cover their treatment appointments.

Bring services to people. Some services would also benefit from being made available remotely or through mobile service provision. Many respondents were excited by the possibilities opened up through technology, from telehealth to phone applications to provider-to-provider remote consultation. Conventional telehealth was a focus, with suggestions to expand reimbursement for remote services. One key informant predicted that, “in the future, we will have phone apps doing the front-end screening to sort out who actually needs to see a provider or not. It's the only way we can actually get the population cared for.” They also proposed providing tax credits to incentivize the creation of tele-hubs where health systems partner with local health organizations “to have peers to do the home visits with the camera, and the health systems own the psychiatrist.” One man working in SU services pushed for mobile treatment options, “[where] you bring treatment in non-clinical settings and bring services to peoples’ homes. Or even just other areas, to make it ... more accessible for the patient.” This is especially promising for services like methadone treatment, which requires regular (sometimes daily) outpatient care by specially licensed providers and is currently unavailable in much of northern Wisconsin.

System Coordination

This section highlights intersections between various components of the behavioral health system, and between the behavioral health system and other service settings. Gaps that respondents and interviewees indicated as emerging from inefficient or disconnected systems are highlighted below.

The lack of coordination between MH and SU systems is a barrier to treating the whole person. As described in the section on workforce and facility shortages, there is a clear need to increase access to integrated MH and SU services. Interviews and surveys highlighted the lack of coordination and collaboration between MH and SU services, which leads to a myriad of gaps in both service sectors. Siloing of services is one of the factors that leads to a “wrong door” situation, where someone seeks help from a service center that isn’t equipped to meet their needs, deferring or delaying treatment. One person suggested, “We ought to have [a] behavioral health treatment center where anybody can walk in with an opiate problem or depression or autism or any... dementia and we ought to be able to help them. And maybe we shouldn't say, ‘Here's the number. Call this place.’” Although referral to other services is an appropriate response in theory, another interviewee noted that “when you're crossing systems, they are moats.” These are the scenarios that lead to people falling through the cracks, at a time when they’ve finally made the decision to reach out for support.

“We need to treat people, not separate the two issues. We still have silos, which is like treating diabetes with insulin, but not looking at diet.”

The separation of MH and SU systems in policy, funding, and regulation makes coordination difficult. A key theme in both interviews and surveys was that the structuring of BHS policies and regulations are a root cause of the friction and disconnect between SU and MH services. Most notably, Administrative Code DHS Chapter 35 and 75 separately regulate service provision for MH and SU services. Respondents felt strongly that this separation was a major administrative barrier for behavioral health organizations that might want

to serve consumers with dual diagnoses. This regulatory separation, combined with distinct funding and billing structures, contributes to siloing of MH and SU services in the state. As one individual working across behavioral health and SU described it, “[There’s] been different funding streams, different provider training, different regulations for each of those types of services historically, so having been treated differently... led to this dual system.”

“So, Wisconsin is not an integrated funding stream state. You’ve got AODA over here, MH over here, adult long term care over there, children’s services over here, foster care over here. So, I think often times, a family could touch any of these funding streams at any particular time in their life. Instead of serving family or the human, we say, ‘Well, we’ll throw some funds over here under AODA. We’ll throw some funding over here under behavioral health. Oh, you’re eligible for Family Care. We’ll pay for some things over here. Oh, and you have a child out-of-home care. Well, that’s a whole different department.’”

County BH system structure creates variability and competition rather than collaboration. Numerous respondents, particularly those working in rural areas, emphasized the limitations of a county-based behavioral health system. One respondent noted, “[Each] county’s got to deal with what they have. And what does their leadership perceive as the priorities of their county? So, there’s tremendous variation for any given patient between one county and another with the same [symptom] presentation.” Often, individuals working at a county level measured their challenges and successes by comparing the available services to those of neighboring counties. In the context of workforce shortages, they also mentioned the level of regional competition for candidates. This competition, rather than collaboration, was framed as a barrier to improved regional service access.

Providers have difficulty getting clarification on how to interpret the various statutes. One repeated frustration was the difficulty of connecting with and receiving guidance on how to interpret and apply the various statutes that govern the system. Providers expressed the impression that there may be a lack of, “agreement on interpretation of statutes by various state agencies/departments/divisions.”

“I work with the CCS program, which is amazing, and I have seen great results. However, there is a lack of communication between Medicaid and providers of clear direction and answers to question. We ask to be set up for success, yet it seems Medicaid does not support this. There is much free interpretation within DHS Chapter 36 and ForwardHealth updates leaving too much ambiguity.”

Behavioral health services aren’t coordinating with primary care providers or professionals associated with the criminal justice system. A number of key informants shared a common concern that there is a wealth of professionals in other settings who interact with people facing SU and MH challenges, but lack the training needed to adequately serve them. One interviewee, a person with over ten years’ experience in SU services, noted, “[Our] whole health care system and criminal justice system is totally ill-equipped to address SU disorders.” This is especially important to note because it is well documented that people with

behavioral health needs who don't receive services often end up interfacing with other systems, because of externalizing behaviors, trickle-down health effects, or routine service access. When police, jails, hospitals, and other health centers aren't able to meet those behavioral health needs, or refer them successfully to receive treatment, people are set up for escalation of their symptoms.

"Everyone you go to for help (911, EMS, PCP, County Health & Human Services, Court System) are not set up to help, everyone points the finger to the next person to go to for "help" you get the run around and it is physically and mentally exhausting and the loved ones trying to help the individual in need and the individual in need of help goes without help and remains in dangerous situations. The level of what is considered to be dangerous needs to be reassessed and something needs to be set up to better help the connection to services before a crisis occurs."

Federal confidentiality requirements for SU treatment creates barriers to coordinated care. Federal regulation restricting communication across providers about SU treatment was identified as another cause of disjointed care. Originally meant to protect people dealing with SU from stigmatization, informants say these privacy restrictions are now a substantial barrier to collaboration between providers working with an individual. When a MH or primary care provider isn't made aware of a patient's SU needs, that patient may receive inappropriate or substandard care as a result.

Stakeholder Recommendations: Improve System Coordination and Cooperation

Within the behavioral health system, coordination between MH and SU services is central to accessible, adequate care. But families and consumers also come in contact with a number of different systems on their way to receiving support, from schools to healthcare to criminal justice. Where these systems touch, there is a need for coordination, and where they overlap there is room for cooperation.

Combine the administrative rules for MH and SU services. On a policy level, there was a strong preference to unify the administrative rules applied to MH and SU services—Administrative Code DHS 35 and 75, respectively. One individual argued that the current division "makes it difficult, because of those different rules ... to treat a person who comes in with co-occurring diagnosis. ... I think the state needs to revise [its] statutes." Another key informant voiced concern about the separation between the MH council and SU council at the state level. They suggested increasing the coordination between councils and increasing council members' expertise in co-occurring disorders.

Combine MH and SU service locations and billing processes. Cooperation at the level of service provision, including integrated care coordination and wraparound services, is another opportunity to improve the accessibility of care. Many interviewees voiced strong support for co-locating a range of services. One person working across MH and SU services in rural Wisconsin argued, "I think you've got to treat the whole person. You can't send part of the person off to ... an AODA group, and part of the person to a MH group. You've got to have it in the same place." For organizations that want to operate in this way, integrating DHS

35 and DHS 75 and putting simplified billing processes in place would alleviate the double administrative burden they currently face. One man summarized both the urgency and difficulty of coordinated care: “[You're] treating the whole person, and I think that that's where all of this needs to start is what is best for the patient. Given the way the current health system is constructed and operated, and its patchwork of payers and regulations, it's hard to determine how you finance that.”

Create a statewide electronic health record system for behavioral health services. Reflecting on a unified database in the state child welfare system, one individual remarked, “I could run reports that could tell me tons and tons of information..... to inform practice and figure out where the gaps are. That information seems surprisingly difficult to get on the DHS, on the behavioral health side. That's, again, because each county has to figure out how to track their own data, and there's no central system.” Another interviewee pointed out that Medicaid has data available, but that the Division of Medicaid Services and the Bureau of Prevention Treatment and Recovery are “still too siloed,” with room for further collaboration. Additionally, within the Division of Medicaid Services (DMS) it has been reported for several years that it is costly and slow accessing its own Medicaid data from the primary repository.

“... [Every] county has its own electronic health record and its own database. The amount of money and the amount of frustration and the inefficiency, and they have to send all their information in different formats to the state...”

The potential to create linked/integrated data from Medicaid, behavioral health, Department of Corrections, State Courts, Department of Justice, Wisconsin Hospital Association would be very valuable, including at a County and Municipal level to target the highest utilizers of services and promote implementation of innovative approaches to better serve this population. For example, a MacArthur study in Milwaukee indicated that 85 individuals averaged over \$60,000 per year each in public services (ER, medical, law enforcement, jail). Targeting these individuals with case management and housing in the community could dramatically reduce these costs. The initial estimated savings for evidence-based interventions was 20% (\$1 million per year of the \$5 million for these individuals) (Jones and Sawyer, 2019).

The use of shared data networks has been successful in reducing the burden of system super-utilizers-- the small group of individuals with severe mental illness that are often requiring emergency intervention and thus consuming a disproportionate amount of state resources. A case study of the Camden Coalition of Healthcare Providers in Camden, New Jersey utilizing a joint data system tracks healthcare “hotspotting” providing updated patient information in real time, giving providers as much information as possible regarding patients presenting at their facilities. According to the ongoing evaluation, this system helps Coalition staff identify people with complex medical needs for targeted intervention programs, which can lead to long term symptom management that may not have been accessible otherwise and appears to be providing significant cost-savings (Milgrim et al., 2018).

“Simplify rules related to Comprehensive Community Services so that you can attract and retain good social workers, providing continuity for consumers. The documentation requirements are driving away good staff. It is time to make CCS and CSP one program, with simplified requirements, still recognizing the varying levels of intensity individuals may want and need.”

Simplify administrative rules to reduce the burden of providing services. A number of respondents commented that the administrative rules governing various services are confusing and would benefit from simplification. In general, there were a number of comments related to the burden of paperwork and

some specific recommendations to reduce the amount of paperwork required to receive reimbursement for seeing clients on Medicaid. Greater technical assistance from the state would be helpful in some cases. For example, “Clear up the confusion about who can provide SU counseling - can licensed therapists with training and expertise do this without a Substance Abuse Certificate? If so, reflect this in the [DHS Administrative] Codes like 34, 35, and 36 that refer to substance abuse providers under 75.”

Increase outreach and collaboration with primary care and other service providers. There are key opportunities to improve consumer access by strategically connecting behavioral health to other systems. For one, there is considerable support for increasing the capacity of primary care providers to initiate conversations with patients about MH and SU. One interviewee remarked, “[If] I go see my primary care doctor and say I have a drinking problem, my primary care doctor should know how to respond to that.” This capacity building on the part of doctors has to come with active outreach by SU and MH providers to ensure patients don’t fall through the gaps in the referral process. Professionals outside of the healthcare system have a role to play as well. Interviewees identified a need to bolster behavioral health training (especially trauma-informed practice) for teachers, childcare providers, police, social workers, and others. One respondent suggested making “early childhood education providers more aware of the manifestations of trauma and MH and substance abuse services.” This kind of integration, they argue, would increase access to care while also diverting individuals from the criminal justice system.

As reviewed in the brief on co-occurring disorders published by the National Association of State Mental Health Program Directors, since 2006 there has been a nationwide shift toward Primary Health and Behavioral Health Integration (PHBHI). However, current evidence suggests there remains much work to be done to ensure both substance use disorder and mental health concerns such as depression and suicidality are both being effectively screened and referred out to appropriate services (Minkoff & Covell, 2019). Additionally, others have found that integrating behavioral health professionals into primary care practices to receive BH support onsite is associated with significant improvements in behavioral health appointment attendance for children and families (Wildman & Langkamp, 2012; Valleley, Hine, Clare, & Evans, 2015).

“More availability of services. A clear list of services is available. I am a mental health provider working in medical hospitals with mental health patients. It is very hard to identify the services that are available out there unless they are systems, or people, I have had personal contact with. It is especially difficult to identify substance abuse treatment.”

Change administrative codes to facilitate collaboration between BHS and the criminal justice system. To the extent that people across the state facing MH and SU challenges are being incarcerated, this has serious implications for the role of both the behavioral health system and the Department of Corrections in intervening in that space.

Ultimately, the criminal justice system on both the state and local level has an important role to play in closing the gaps in access to behavioral health. At the front end, individuals externalizing SU or MH needs must be diverted to healthcare solutions rather than incarceration. That shift must go hand-in-hand with efforts to expand the behavioral health workforce and facility capacity.

“Right now, the way the statutes are written, 30[sic] and 75, among others, do not allow county mental health agencies to cooperate very well with providing mental health services and AODA services in the jails... So, some legislation needs to happen to remove that barrier that would allow county mental health agencies to cooperate more closely with local law enforcement, to help treat and serve those individuals who are incarcerated and have mental health or substance abuse problems.”

Create structures for cross-county behavioral health system coordination and resource sharing. One person working in MH suggested, “[We] actually could think about moving our system to not be so county-focused and be more regional-based. We know we don't have enough providers and it just would make more sense to have something be more based on a region so everyone in that area could have access.” This shift could come through regionalizing funding structures, unifying behavioral health data systems, strengthening regional behavioral health coordination and leadership, or investing in hub-and-spoke or telehealth models. This recommendation was suggested to address the barriers created by geography, as well.

“Utilize the available auxiliary services like vocational training, recreation therapy, occupational therapy, etc., to offer more meaningful treatment options (as opposed to just medication management and individual therapy).”

Service Adequacy Barriers

In the context of long wait lists for services and limited financial resources, prioritizing training for staff to incorporate evidence-based practices (EBP) and best practices can be difficult. Respondents emphasized that access to care is their primary concern, and that fidelity to EBPs is secondary. Nonetheless, in addition to outlining the themes related to service access, reflections that were shared regarding EBPs and best practices in the BH system will also be highlighted.

Evidence based practices (EBPs) are one key component of adequate care in the behavioral health system. Generally, EBPs are practices which have been shown effective by experiments that control for outside factors and random person-to-person variation. In the context of EBPs, fidelity means providing a service or treatment in a way that replicates the model tested in research. Without fidelity in EBP implementation, the outcomes for patients may not reflect outcomes reported in experimental trials. This is not the only kind of

knowledge that can or should inform behavioral health care, especially because research evidence evolves over time. All the same, EBPs are valuable tools in a provider’s treatment toolkit. It is also worth noting that some interviewees also discussed treatment paradigms (beyond individual treatments) and best practices as part of evidence-based care.

Change the status quo to emphasize treating the whole person. There were numerous calls for a paradigm shift in behavioral health in Wisconsin, towards people-centered, wraparound, holistic care. This theme overlaps with solutions related to systems coordination but is more centered on the quality of care and consumer experience. One interviewee suggested, “I would argue that a care coordination model, versus a case management model, would make sense. ...You're working with somebody to address their needs much more globally, as opposed to just connecting them with assessment, monitoring, and referral.” Another person reflected on the benefits of a person-centered approach in the area they work: “I think if we could be at a place where we're a community that provides more holistic health, I think it would certainly cost a lot less than it does now.” This echoes the proposed benefits of a prevention-focused approach to care; together, these broad shifts could help reduce system-wide costs and improve outcomes for Wisconsinites in need of care. Other respondents suggested broadening the focus beyond medication management.

“Consider funding alternative approaches to treatment, i.e. fitness coaching, acupuncture, art and music therapies to offer more appealing service arrays that make people want to seek services and drop health care costs across the board addressing both physical and MH which are intertwined. Medications, therapy and substance abuse groups are not a one size fits all approach to treatment.”

“Individual service provider need to look at and address their client termination policy. Many consumers have been terminated from treatment with a time frame due to symptoms of their disorder. This is a very common issue within our community.”

Existing recovery homes and sober housing with total sobriety (no MAT) policies push out consumers on the road to recovery. Traditionally, SU recovery programs have emphasized total sobriety as a precondition for recovery. Although many 12 Step Programs have made significant changes and strides in their acceptance of MAT and are diverse groups with differing views, some interviewees with experience working in SU services felt this more traditional approach excluded people with more complex paths to recovery. One consumer advocate working across SU and MH services recounted, “There's some of these recovery homes, you can't be on medication assisted treatments. In a lot of these recovery homes, if you do slip and use, you're kicked out. They don't necessarily understand that recovery's nonlinear, that we have setbacks and we move forward.”

Zero-tolerance policies for SU is a misunderstanding of the road to recovery. Several survey respondents raised concerns about provider policies that drop consumers from treatment too early in the recovery process. For example, it was repeatedly noted that many providers have three-strike policies that kick out consumers if they miss an appointment, or if they relapse in their SU. As one respondent put it, “Clients relapse. It's part of recovery, yet programs only allow clients to participate so many times, which may prevent them from getting needed treatment when they are actually ready.”

“My biggest gripe is the mental health complex. I’ve been there like 30 times from I’d say December 16 to May 17. Every time I get there, well, you’re drinking, we’re not going to give you no medications, go away. Otherwise, they send me to detox and I’m back in a couple of days, and again, it’s go away. I don’t get that. I go there for help. Okay, you’re .08, get out. They either kick you out the door in the morning or like I say, send me to detox and I’m back in a couple of days.”

Although more MH professionals can provide SU services, they are inadequately prepared to do so. The separation between SU and MH services was thrown into the spotlight with the passage of Act 262. With that legislation, the door was opened for a range of MH professionals to provide SU services. This change was mentioned in interviews as a point of contention for those working in the SU field, in large part because they didn’t feel the regulation required enough SU-specific training for these new providers. One person with over ten years of experience in both MH and SU services argued, “[If] you've never had specialized training in substance abuse... I don't think you should be working with a substance abuse client.” Others argued that in its implementation, 2017 Act 262 failed to substantially increase the number of SU providers. One man working in both MH and SU noted, “If a mental health practitioner is providing AODA services within their scope of practice, but their license doesn't say that they're an AODA counselor, Medicaid is still not reimbursing for that. So, that's a hole that needs to be plugged in terms of making 2017 Act 262 fulfill its original purpose.” Although many acknowledged that increasing the number of providers able to serve those with SU needs was ultimately a positive development, our informants’ perspectives indicate a need for increased scrutiny of how 2017 Act 262 is being implemented and its effects on the quality of care for consumers.

Licensing requirements and Medicaid funding restrictions limit workforce expansion. In the survey, a number of respondents highlighted administrative barriers they have encountered when they

“This population that requires both MH and SUD treatment needs specialized training and experience. Someone only trained in mental health and not certified in substance abuse counseling could potentially do more harm to long term recovery.”

attempt to hire and thereby expand the workforce. One barrier was that in the context of poor reimbursement rates that haven't increased in years, rural providers are unable to get recently graduated students with a Master’s in social work the required hours for licensure since they will not be reimbursed for the work of the MSW. As one provider explained, “The 3000-hour requirement for MSW to become an LCSW is not working currently. As rural facilities, we are only reimbursed for LCSW services and these

individuals cannot find well-paying programs to get them the hours needed. We aren't growing new clinicians fast enough.”

Bright spot: Awareness of evidence-based practices is high across the state. In interviews, there was a lot of optimism about increasing use of EBPs and best practices around the state. One man recounted, “I think everybody's aware of [evidence-based practice] these days, around 20 years ago that wasn't true.” However, many interviewees noted continuing gaps in the availability of EBPs, ultimately impacting the quality of behavioral health services. When specifically asked about which EBPs they would prioritize, respondents highlighted a range of treatment paradigms and specific EBPs listed below. Because key informants and survey respondents were predominantly administrators and advocates as well as individuals directly involved in behavioral health treatment, some individuals had much more specific and detailed suggestions in this area. As a result, more commonly known EBPs and best practices were mentioned more often, and more targeted ones may have only come up in a handful of interviews. Some respondents declined to recommend specific EBPs, because they were not involved in patient care directly. Table 8 details the full list of evidence-based practice recommendations identified via the survey.

Table 8. Evidence-Based Practice Recommendations from Survey

(listed in no particular order)

Trauma-informed care and harm reduction	Therapeutic Wraparound Crisis Response
Person-centered care, strengths-based, recovery-oriented	Multidimensional Family Therapy
MAT	CAMS
Prevention programs	Aggression replacement therapy
Cognitive Behavioral Therapy	EMDR
Dialectical Behavioral Therapy	Child-parent psychotherapy
MATRIX (for meth)	
Suicide safe care, zero suicide	
Motivational interviewing	
Assertive Community Treatment	
Coordinated Specialty Care	

Use of EBP language may obscure the reality of practice. Although the use of EBPs was generally agreed upon as a goal, a number of interviewees pushed back against the primacy of EBPs and some specific ways it has been mobilized in behavioral health. Some argued that the use of best practice and evidence-based care *language* ultimately allows poor

practices to fly under the radar. One man in the MH system argued, “[We] don’t have data other than this: I would submit that if best practice were being followed then we wouldn’t see kids fail repeatedly. We wouldn’t see families torn apart by removing the child.”

“Therapists use evidence-based approaches, but not in the way the evidence suggest it’s helpful, say, they’ll do EMDR one day, and some aspects of TFCBT another day, but do not implement the EBP for the duration and frequency required that evidence showed made the approach effective.”

Providers lack the resources to implement EBPs with fidelity. According to key informants, staff capacity and the lack of ongoing training and oversight were the greatest barriers to the uptake and effective implementation of EBPs. Training for providers is expensive, because it is non-reimbursable time that could be spent on other things. Beyond training, interviewees emphasized that effective care requires ongoing support and supervision to ensure that EBPs are implemented to fidelity. “The problem with training for me though is you can’t just train somebody once, it’s that ongoing supervision coaching support piece that needs to be built into the system as well,” one person argued. These issues are especially relevant in the context of widespread workforce shortages, which make it difficult to recruit staff with the necessary training in EBPs. Difficulty hiring enough providers also stretches the capacity of the staff organizations are able to retain. One person reflected these challenges, noting, “People want to use best practices and fidelity models with everything. But it doesn’t happen all the time because ... of too much need and not enough time, not enough staff, people who have the ability to provide those services.” Additionally, hiring supervisors to ensure fidelity was noted as a prominent challenge”

“I think we overemphasize talking about trauma, but we don’t really embody what it takes to provide services in a trauma-informed way and a culturally acceptable way.”

Low staffing rates across provider roles creating strain and burnout. Among survey respondents, *an insufficient number of providers entering the field to address workforce shortages* ranked as the #1 and #2 workforce conditions perceived to be contributing to the gaps in MH and SU services, respectively (refer back to Figure 9). This condition was followed closely in rank by the salary and benefits are too low to retain providers and in explanations of the link, most informants identified poor pay as a key cause of low staffing rates. Although prescribers and residential care were the most broadly and strongly identified gap in interviews, staff, administrators, and advocates emphasized the challenges associated with a generalized strain in the labor pool for roles across their organization. Low staffing rates across the board, from direct service providers (e.g., therapists, SU counselors, social workers) to front line staff without advanced degrees, is creating role strain and is precluding the ability of the existing workforce to either seek professional development or engage in outreach with the community. Not only are workforce shortages leading to gaps in care across the state, but they also decrease the capacity of existing behavioral health

workers to seek training or do outreach in the community. This severely limits the ability of behavioral health providers to seek substantive cultural competence training, or to even reach those communities whose needs aren't currently being met. One person working in the MH field noted, "[We're] not always the best in our state about doing outreach because we're always at our capacity, so outreaching to help people who need it and are underserved is kind of the last thing on everyone's mind... because they're already maxed out."

"Higher compensation and lower caseloads. This field is overwhelmed with provider fatigue. We ask these clinicians to work with patients who have significant trauma history and saturated histories of abuse and neglect. Then we ask these clinicians to see more patients, bill more hours, and we compensate less. By the time a clinician is truly competent and has put in the time to be proficient in their area they are completely burnt out and have often left the field completely."

Stakeholder Recommendations: Improve the Adequacy of Existing Services via Workforce Development and Accountability

Even when services were available and accessible, those services aren't always adequately meeting the needs of consumers. Some interviewees identified issues with the approach to care, while others pointed out gaps in the availability or implementation of evidence-based practices. Issues related to culturally appropriate care are covered in depth in a subsequent section. To address these challenges, interviewees highlighted current successes around the state as models that could be expanded on and proposed process and implementation changes to improve current models of care. Below are the themes that emerged from these discussions.

Update the code for children's mental health services. One individual working in the children's MH field across Wisconsin argued, "The second thing that we would prioritize is creating a separate children's MH code in the state statute. Right now, it's all combined in Chapter 51, and Chapter 51 was enacted in 1975, and since then we've had a whole bunch of enhanced understanding about child and adolescent brain development. We now know that what works for adults is different than what works for kids ... And so, we recommend [the] creation of a children's MH code that ensures those elements."

"The mismatch of legacy children's programs for AODA and MH is wasteful and inefficient. The referral assessment for families is way too complex and a family cannot possibly understand the services available because of our systems. Move children's AODA and MH services from the Children's Long-term Support Serious Emotional Disorder waiver program into the Coordinated Services Team Initiative."

Shift the assessment, eligibility, and care monitoring processes toward a more person-centered and holistic approach. Many interviewees called for a paradigmatic shift in behavioral health in Wisconsin,

towards people-centered and holistic care. One interviewee suggested, “I would argue that a care coordination model, versus a case management model, would make sense. ...You're working with somebody to address their needs much more globally, as opposed to just connecting them with assessment, monitoring, and referral.” Another person reflected on the benefits of a person-centered approach in the area they work: “I think if we could be at a place where we're a community that provides more holistic health, I think it would certainly cost a lot less than it does now.” This echoes the proposed benefits of a prevention-focused approach to care; together, these broad shifts could help reduce system-wide costs and improve outcomes for Wisconsinites in need of care.

Examine the appropriateness of existing supervision requirements for SU credentialing. Some respondents felt that the supervision requirements built into SU

services represent an undue burden on providers, particularly when compared to similar requirements for MH services. Removing this barrier was seen as a potential way to encourage the growth of the SU workforce. However, others were concerned that many recently certified SU providers are inadequately prepared for providing SU services. This conflict suggests that the current approach may represent a one-size that does not fit all.

“Get rid of the requirements for AODA supervision and make them in line with current MH if the provider is Master’s level. Very burdensome for clinics and providers don’t want to do AODA due to the cost of time involved with current requirements.”

Make trauma-informed care a universal baseline within BHS. The paradigm of care, or the general approach that providers take to services, is a cross-cutting issue that impacts the quality of available behavioral health services. Shifting the paradigm of behavioral health care towards more evidence-informed approaches was a stated priority of many interviewees. Professionals from across the spectrum—providers, advocates, and administrators— emphasize the importance of increasing the use of trauma-informed and harm reduction approaches across all types of services. One provider made the comparison, “Trauma-informed care, in many ways, is like universal precautions in the rest of medicine. ... [In medicine] there are certain things that I need to do, to presume that anybody might have an infectious disease, that I don't get it and they don't get something from me. ...[Trauma-informed] care is that way.” Many recognized that these principles have become increasingly mainstream in the behavioral health field. However, some also highlighted that although trauma is now part of the conversation, providers and organizations don’t always walk the talk.

“Recognize the effects of trauma, help individuals see the physiological relief that their drug(s) of choice bring them and develop coping strategies that offer the same relief.”

Prioritize recovery-oriented systems of care. In order to counteract the perception that recovery from SU is linear and after a certain point the individual is no longer in need of support, several respondents suggested funding should prioritize care models that focus on the long view of recovery. This was also highlighted as an important place to utilize peer specialists to support, “people waiting for treatment services, as well as those completing treatment services to transition into a new lifestyle and get connected with the community.” Others have gone so far as to suggest, “The entire CBRF/AFH [community-based residential facility/adult family home] statute needs to be rewritten to be focused on recovery.” This recommendation to focus on recovery dovetails with the

recommendation to expand the view of recovery and wellbeing by endorsing an emphasis that “peers have their own ability to heal in a recovery-based model and not be imposed on by providers, psychiatrists, and those diagnosing especially.”

“Focus on recovery as the goal [long-term versus acute treatment] and increase funding around recovery-oriented systems of care to include community-based supports, recovery-coaches, funding for multiple pathways to recovery (12 step groups are not for everyone and do not work for everyone). Use evidence-based treatment approaches.”

If the use of EBP is a priority for the BH system, provide financial support and incentives for

implementation. A number of recommendations were offered to address the challenges in creating a BH system that employs EBPs. The suggestions ranged from improving education before entering the field to providing a higher reimbursement rate to providers that implement EBPs. Increasing reimbursement rates would also reduce caseloads allowing time to address self-care concerns and seek adequate supervision needed to maintain fidelity to EBPs. One person argued, “I think training needs to be available, and then we need to have the funding to make it affordable in the first place for either county to train their staff or for individuals as professionals to seek that training themselves.” Another individual suggested that costs could be offset (and implementation incentivized) by increased insurance reimbursement rates: “We need enhanced Medicaid rates for delivering evidence-based practices and making really true outcomes happen for people.” These shifts could help providers make strides towards effective and quality care.

Decrease the time it takes to get licensing approval. A common challenge noted in the survey responses was the amount of time

“Improve DSPS services and barriers to timely licensure and means to obtain licensure or certification.”

it takes to get a new provider’s license approved by the State. A number one priority identified by more than one survey respondent was to “Fix the ‘black hole’ at DSPS. The wait time for credentialing is horrible. We have hired individuals who have had to sit, non-billing for over 6 months because of them.”

EBPs may not always be the best fit. One person suggested that behavioral health needed to expand its frame beyond EBPs, saying, “We also have to make room for innovative services, things that haven't been validated scientifically, but are... promising practices.” Another interviewee critiqued how EBPs are coded as the default best approach for all people, overriding or replacing community knowledge and perspectives.

Noting how grants for services prioritize the use of EBPs, and the cost of curricula, she suggested “We do all of this evidence outside of those communities and then make it a [funding] requirement... to provide that service there at pretty expensive curriculum costs, and instead of reversing that and saying ‘Well, what’s working in your community and how can we grow that for you?’” This story is a useful reminder that research evidence isn’t - and shouldn’t be - the only way to validate the effectiveness of behavioral health services.

Invest in ongoing training, supervision, and outcome measurement. Interviewees expressed disappointment with the prevalence of “one-and-done” training. They emphasized the importance of ongoing training and oversight to ensure EBPs are implemented with fidelity. One man working in the MH system argued, “[The] counties and providers need to ... understand what it is to implement evidence-based practice. They have to initiate these services in a scientifically viable manner, so using principles of implementation science, which includes ... includes clear organizational changes, leadership adjustments.” Executing EBPs as an organization to fidelity means more than just training. Establishing clear benchmarks for EBP implementation, from practice to monitoring and outcome measurement, would ensure that patients receive the intended course of treatment regardless of where they live in the state.

“In order for clinicians to remain trauma-informed, they must be able to have adequate supervision and self-care. Our current system is so focused on billable hours, out of necessity to survive, that our clinicians are becoming very unhealthy. Supervision is a burden as it is not a billable activity. Supervisors are expensive as they do not produce billable time. These are system failures that lead to poor outcomes for our consumers.”

Cultural & Stigma Barriers

As mentioned in the section on workforce and facility gaps, culture is a concept that refers to a variety of dynamics that can also impact the accessibility and adequacy of services. For example, the norm in some cultures is to not seek help for behavioral health issues which is a barrier the individual and the provider must overcome. The option of accessing a provider or a service that is a cultural match to the consumer can remove the barrier of navigating mismatched expectations between the individual and the provider.

“Certain substances (i.e. alcohol) are socially acceptable and embraced in Wisconsin, so seeking treatment or maintain sobriety is not socially supported. Many people also continue to see addiction as a choice vs. a disease process, even mental health and other health care professionals.”

Respondents who indicated that cultural barriers played a role in any or all of the service array components mentioned in the survey were then asked to indicate from a list of forced choice options which specific cultural barriers played a role. Across the service array, responses were very similar, with ‘Lack of service providers that share a background or identity with individuals seeking treatment,’ and ‘Stigma about mental

illness in some cultural groups discourages seeking treatment’ vying for the most frequent cultural barrier for all service components except for MH crisis/emergency services. For MH crisis/emergency services, the first spot was ‘Lack of service providers that share a background or identity with individuals seeking treatment, followed by, ‘Some cultural groups do not trust the healthcare system.’ This is not surprising given the feedback that crisis/emergency is most likely to involve police and subsequently send some consumers into the criminal justice system.



In the survey, these **cultural barriers** to access for substance use and mental health services were identified with similar frequency...

- Stigma about mental illness or substance use discourages seeking treatment
- Lack of service providers that share a background or identity with the people seeking treatment
- Some groups do not trust the healthcare system
- Available treatments are not adapted to the needs of some cultural groups
- Lack of service providers with non-English language proficiency

Stigma Regarding Behavioral Health Needs

Stigma messages and ideologies - such as the quote above - justify policies and practices designed to harass, exclude, and eliminate individuals from minority or stigmatized groups. The shame that manifests when one belongs to a stigmatized group often serves as a barrier to seeking support for managing the stigma or the results of dealing with stigma such as addiction to a variety of substances (Hatzenbuehler, McLaughlin & Nolen-Hoeksema, 2008; Hatzenbuehler, Phelan & Link, 2013). In all, stigma is thought to serve as a fundamental driver of population-level health inequities by increasing stress and decreasing access to the personal and institutional resources needed to cope with it. Thus, the cumulative effect of exposure to stigma is the erosion of group members’ physical and psychological well-being (Nadal et al., 2011; White Hughto, Reisner & Pachankis, 2015).

“This does not happen here. Those people are losers. Let them die. Not my kid, parent, friend. They came from a bad family. Lazy. Never should have started using-they are dumb. They don’t want help.”

Misconceptions that those with MH challenges are “just someone with poor morals and lack of a good work ethic” can often lead to ineffective or inadequate treatment for consumers. Stigma messages regarding MH described in the survey included a focus on a belief in the instability of individuals seeking MH support and fear of subsequent ostracization from communities. In the survey, respondents identified that, “Individuals with mental health issues are

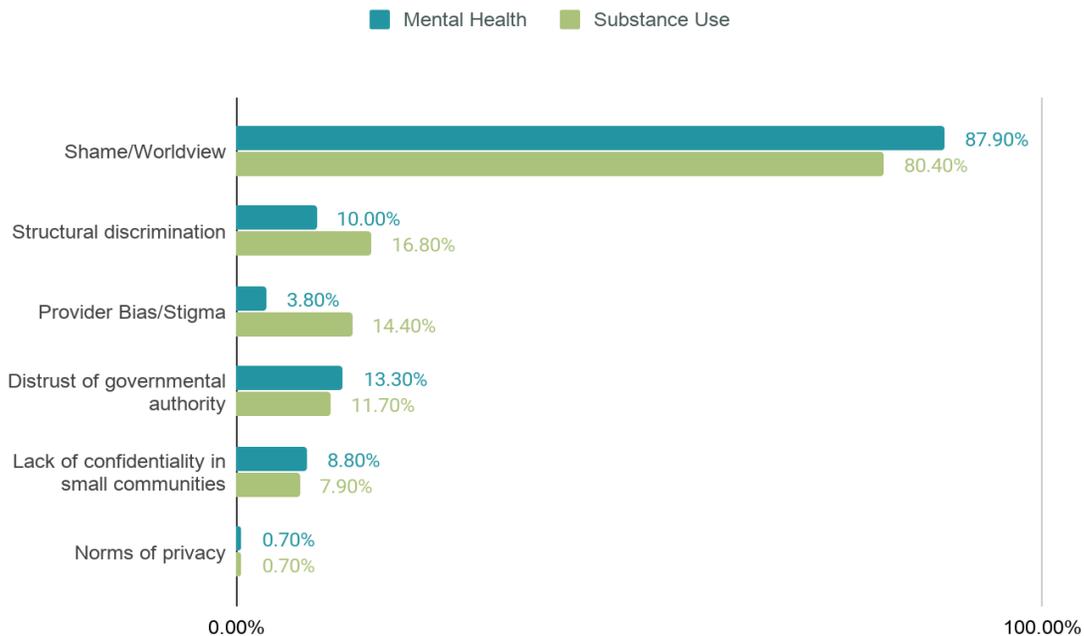
seen as dangerous and unpredictable; unable to recover.” While others expanded on how stigma functions as a barrier to treatment with greater specificity: “Some of the groups of people in Milwaukee feel that they are looked at as being ‘crazy’ or weak if they seek MH services. Society looks down on them and excludes them from community activities.”

“The stigma attached to both mental health needs and substance use prevents individuals from receiving assistance or speaking to others about their condition. There needs to be more awareness of the programs in the area, for those who are not comfortable speaking to their primary care provider.”

Stigma messages regarding SU were described in the survey as framing addiction as inherently criminal, noting: “Substance use disorder is viewed as a choice by the individual, not a disease, and ‘it’s their own fault this is happening.’”

In the survey respondents were first asked to indicate whether or not they thought there are stigma barriers for accessing BH services in the area in which they work. If they indicated ‘yes,’ they were then asked to describe the stigma barriers they perceived. Their open-ended responses were coded, and the following themes quantified: shame/worldview, structural discrimination, provider stigma, distrust of governmental authority, lack of confidentiality in small communities, and norms of privacy. Figure 13 shows that the vast majority of stigma barriers for MH and SU services were affiliated with the world view that requiring BH support is a mark of weakness, criminality, or instability and consumers feel ashamed.

Figure 13. Stigma Barriers for Mental Health and Substance Use Services



During the focus groups and workshops, many residents shared their stories accessing or attempting to access MH services and experiencing paternalism, fear, shame and harm from providers and institutions. These experiences highlight one of the many barriers that people face when trying to utilize MH services in Wisconsin. Additionally, in the focus groups consumers highlighted that social norms tend to encourage individuals not to discuss MH at all.

Provider stigma -- or bias amongst providers toward consumers -- was more commonly perceived to be a barrier in SU services than in MH services. This was also the case for fear of facing structural discrimination, which included the possibility of losing one's job or one's children if others knew about service access.

"If there is a substance abuse clinic in the area, the surrounding neighbors immediately think their city is going to go 'downhill,' like everyone who [has and addiction] is a bad person. Will someone lose their job if they are seen at the clinic? How can there be more discreet treatment?"

Fear of facing structural discrimination serves as a barrier to seeking help. Both key informants and survey respondents highlighted that there are often material consequences for consumers after they seek BH services and that these consequences, in turn, serve as a barrier to access for themselves and others. In the survey, more than one medical professional described that discrimination in response to learning that a patient receives BH care is real: "Mental health diagnoses are visible in the electronic chart where all medical staff can see this. Biased treatment is then given when that patient seeks treatment in the emergency room. I have witnessed this myself. There is a huge stigma with these diagnoses, even with professionals." Other providers highlighted that often consumers find that their subsequent medical concerns are pushed aside as psychosomatic after they seek BH services. "I work in [a] medical hospital. If someone has a history of MH issues, medical providers will assume the condition related to MH rather than physical. People with MH conditions do have physical conditions as well."

"Some people with cultural/language barriers do not want to access behavioral health due to fear of 'being turned in' to immigration."

Previous negative experiences with the behavioral health system reinforce stigma barriers. Having one (or many) negative experiences with the BH system prompts many consumers to avoid the system for life. As one key informant described, "And a negative interaction or a negative relationship to that kid, they often

"People have had experiences with the MH systems and providers interacting with them in a manner they found to be disrespectful, condescending, highly negative, punitive, non-recovery based and non-trauma-informed, and often actually re-traumatizing. This leads to them feeling stigmatized and wary and/or unwilling to engage with the MH system."

make the assumption that's the way it's going to be with all providers. And a lot of kids, they get in that 18-age range and they're like, "I'm done, I don't want treatment. I don't want to talk to these people."

Seeking BH care can be used against you in court. Others identified that there have been observable legal ramifications to consumers of BH services because of the stigma. Specifically, it has been repeatedly noted that seeking support will be held against you at a later date. As one defense attorney noted: “I am a defense attorney, so all of my clients are involved in the court system somehow, and often [an] individual’s MH or AODA concerns are discussed in open court as cases are making their way through the system.” As another survey respondent described, “By reaching out and asking for help from the County (when they are unable or unsure of how to access it on their own), some have found themselves under scrutiny and at risk of losing their kids. More non-County prevention services need to be made accessible, so families can ask for help without fear of reprisal. “

Founded fears of experiencing workplace discrimination if and when your employer learns of these BH needs inhibits health seeking behaviors. Getting passed up for promotions or other opportunities because of stigma is a type of discrimination that is notoriously difficult to substantiate even when true. “People are afraid of being labeled as ‘mentally ill.’ The media has associated mental illness with violence, especially mass shootings and workplace violence. People are worried that a MH diagnosis may count against them at work, seeking promotions, raises and health insurance.”

Sometimes family members’ reputations will be held against consumers seeking help. In some cases, survey respondents felt services could be affected by who you are affiliated with. One wrote: “I think, in particularly smaller areas, there is a lot of bias. We had a situation in a county where a family needed assistance and the county wasn't really doing what they needed to and it was because this family, even not this particular, but sisters, brothers, mother, father, grandparent, whatever had a reputation.”

“The pockets of resistance that I meet the most still are the health care system, physicians and health care administrators. Again, I literally talked... I used to work in a health care system, I was talking about doing opioid treatment and they said, “We don’t want those people in our lobby.””

Stigma amongst providers creates gaps for consumers who use substances. One particularly common theme was that providers both inside and outside of the BH system carry stigma regarding SU. As one respondent described: “In certain areas of Wisconsin there is a lack of understanding what addiction is and that recovery is possible. Stigmatizing language is still being used throughout Wisconsin by providers, first-responders, doctors, and the media. Some doctors and other staff in emergency rooms throughout the state still refer to people as junkies and frequent flyers and try to get them out of their emergency rooms as soon as possible.” Alarming, there is the perception that in some pockets of the state this stigma is held by first responders as well: “We even have Emergency Medical Transports who refuse to carry Narcan because ‘those people deserve to die.’”

Stigma regarding addiction and mental health causes tension across the service arrays. A common sentiment across interviews and survey data was that according to professionals, there is a, “lack of communication, mutual respect between MH and SA professionals.” More globally, a lack of empathy for addiction is observed in medical professionals and other police officers. Additionally, professionals felt there was a misunderstanding that training in MH is sufficient to treat consumers managing addiction: “Medical providers lack empathy and knowledge in how to treat intoxication withdrawal.”

The stigma regarding substance use is experienced as a lifelong barrier. One respondent described the lifelong impact of stigma from their own experience: “Judgement. I have been clean off drugs since 2015. I had a doctor last year tell me that she didn’t believe me. It feels like once an addict, always an addict. The idea of a recovering addict is not even considered. I wake up every day deciding to be clean. But everyone else in the medical field does not see it that way. I have had some good experiences.... which has been great, where they complement me on my strength instead of focusing on my weakness of past drug use.”

Behavioral Health Stigma in Rural Areas

Although the privacy norms were highlighted as a particular concern in more rural areas, it was the least often mentioned stigma barrier. When asked to reflect on particularly underserved populations, several key informants highlighted concerns that farmers and other rural Wisconsinites may not frame challenges in terms of behavioral health: “I think there still is a lot of access stigma in certain parts of the state. I think any place that's rural, that doesn't have to deal with the same density of problems that other places do, may have a little bit more reactionary to some of those ‘big city problems.’” Respondents indicated that this was due to a misunderstanding of what behavioral health really is and why it is needed.

BH stigma in rural populations may be particularly deep rooted. When asked to reflect on why certain populations are more likely to fall through the gaps in services, in rural areas, survey respondents and interviewees highlighted farmers as particularly unlikely to seek services. Their responses echo statistics which show that white, male farmers face the fastest growing rate of suicide attempts in Wisconsin (Rural Health Information Hub). One interviewee recounted, “I think the farming community could be a population that is overlooked. Not necessarily underserved, but I guess going back to that culture piece, from what I know about the farming community is they are very strong, very independent, hardworking people. Stereotypically, that's not a group that might seek help. There's actually been some specific outreach in the Southern part of the state to bring attention to that.” Others thought that in addition to being fiercely independent and private, there is likely some degree of shame that reduces help-seeking in rural populations: “In the rural area, persons in need may be too embarrassed to seek help. For example, farmers are often too embarrassed. Cultural differences are also there with our local Hispanic community. There appears to be a stigma for MH and substance disorders with that group also.”

In small towns and rural settings, confidentiality is particularly challenging. A key barrier raised in every discussion of BH services in rural areas was the concerns about confidentiality. “Shawano County is a small rural county, where everyone knows everyone. It is uncomfortable having to go to a facility where everyone uses the same waiting room and entry/exit door. It is not uncommon to run into someone you know. So, is this really confidential? “

“Some people don’t want to be seen accessing these services in the community or are fearful of the neighborhoods where they are located or they’re fearful that word will get back to loved ones that they were seen there or they’re fearful loved ones will call them crazy or lazy or whatever other blame can be assigned.”

Co-housing BH services with county services associated with a law enforcement creates a barrier. One particularly concerning barrier that can emerge when BH services are co-located with law enforcement is that being surrounded by law enforcement may actually trigger the central nervous system due to historical and/or recent trauma associated with law enforcement: “having county MH services located in Eau Claire and Chippewa in the same building as the court house can certainly create a traumatic experience for anyone with past law enforcement experience to want to continue/engage with these services.”

“People feel that connecting with the county means they are not good people. They are often involved with CPS, court systems, probation etc. We are representative of that system even though we are a treatment provider. People are scared of what treatment is going to mean and that we will force them to do things they don’t want to do.”

Marginalized by the System: Themes in Health Inequities by Population

According to the World Health Organization, health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age (Solar & Irwin, 2010). Accordingly, health inequities in the behavioral health system refer to an unfair, predictable distribution of services, or in the unfair distribution of the negative consequences of gaps in service provision.

As was noted by survey respondents, consumers that sit at the intersections of these marginalizing forces often experience the largest challenges to securing treatment. For example, “parents with cognitive, mental health issues, or those of lower socioeconomic status are particularly harshly judged and... are less likely to be included in care and treatment decisions for their kids.”

This section highlights the mechanisms that marginalize certain populations, such as the lack of diverse providers and interpreter services. More detail regarding the populations that were identified to be more vulnerable, unnoticed, or disproportionately affected by these gaps in BH services than others is also provided below.

Bias at the Intersection of Criminal Justice and Behavioral Health

In some areas without available inpatient or residential treatment, prisons and jails are used to address behavioral health crises. Wisconsin's disinvestment in institutional MH care has displaced individuals into the corrections system. In the absence of accessible residential care, some individuals are detained in prisons or jails, where they may not receive behavioral health care. One person working in the field of MH services commented, "I can't tell you the number of individuals that I worked with, who literally would not have been in jail if there had been someplace else for them to go. They were strictly in jail because they were assessed to be unsafe, or just ... it was clear that they couldn't be left at home." These scenarios were

"States lock people up in cages for their mental health challenges, that's the opposite of support."

mentioned in the context of rural and small-town areas, where residents tend to be further from existing services.

Implicit bias is perceived to contribute to incarceration, rather than referral to care, of people of color with behavioral health needs. Bias against certain groups and stigma around behavioral health crises can determine whether an individual is directed to behavioral health services or the criminal justice system. In the context of rural jails, one individual recounted a conversation with one jail captain, who said he dealt with recidivism among individuals using drugs by "[locking] them up longer." However, the same interviewee argued that this was an exception, and not the rule - that in his experience, people working in rural jails knew that there was an unmet service need. Based on our interviews, this is not the case for people of color. One person described, "I do think kids of color are often the ones who are slipping through

"Systemic/institutionalized racism and cultural ignorance is a huge issue. Those who need inpatient mental health treatment are feared or seen as threatening and end up routed to incarceration instead."

the cracks or they more often get fed into the youth justice system rather than typically the MH system.... [Too] often, handcuffs are an entry point for young people to get into a system of care."

Implicit expectations about people of color on the part of police, teachers, providers and other professionals limit youths' ability to access care and contribute to the disproportionate representation of people of color in Wisconsin's jails and prisons. As one interviewee noted, bias toward low-income adolescents skews the odds of getting treatment, as well: "even in my community we don't have a lot of kids of color, but we have the poorer kids and the wealthier kids. And the kids that come from the 'better families,' they have behavioral issues, that's more often they're diverted to treatment, whereas if it's from a lower income family or one of those families, they're just considered delinquents and treated as such."

Few transitional services exist for incarcerated citizens.

The lack of support to citizens transitioning out of incarceration was a key area of concern for survey respondents, particularly around

“People on probation/parole are expected to: see their PO at a moment’s notice, have a job, pay their bills, abide by all the rules of their supervision, to include staying sober, effectively removing the ONE coping skill they had mastered. When are they supposed to get some mental health help?”

the management of addiction. As one respondent noted, “There is a lack of knowledge in corrections about treatment once released and agents are unsure of resources, nor are they educated in deciding what treatment someone should receive. Corrections lack in linking clients from ‘treatment’ while incarcerated to treatment once they are released as social workers or treatment providers in prison are overwhelmed with their caseload.” There were a number of calls to more effectively coordinate “with jails to connect inmates with MAT BEFORE release,” and to “encourage additional privately-owned, tenant-funded, sober living opportunities for adults coming out of jail/prison.” In all, the sense was that the lack of services targeting this population was reflective of the stigma attached to incarceration, and since African American residents in Wisconsin are much more likely to be incarcerated than any other racial group in Wisconsin, this gap in services exacerbates existing inequities.

Historical and Emergent Community-level Trauma

Historical trauma and distrust of government authority.

Concerns regarding distrust of the BH system as an arm of governmental authority were raised via all forms of data

“It’s cultural too, and then I think about ancestral memory or how were Black people treated in mental health facilities 100 years ago... [if] you think about it, we have no reason to ever trust an institution”

collection. As one respondent articulated, “People fear the system. They fear losing their jobs, children, their integrity. They fear the ‘state’ or the ‘system’ will lock them up, or chapter them for using services. They may have always been involved within the system therefore will not seek help for treatment due to retaliation from law enforcement/court systems.” As stated earlier in the report, the concerns of the biased use of governmental authority are heightened by current reliance upon police involvement during psychiatric crises.

According to the nationwide survey of law enforcement agencies, many officers share the concern that interaction with a police officer when a person is in crisis is more often than not (65% of the time) unwarranted as they are rarely deemed a threat to others. In this report the officers disclosed observing how their appearance can seem to escalate individuals in nonviolent crisis and then create trauma for the individual and their family as the person in crisis is placed into restraints and transported in a cage like a criminal. Treatment Advocacy Center, 2019).

“[Crisis] Involves law enforcement by default, further stigmatizing and criminalizing mental illness and preventing people from asking for help.”

The absence of diverse providers was identified as a barrier precisely because of historical trauma: “due to the historic trauma many [members of the La Courte de Oreilles tribe] refuse to seek or engage in services for lack of trust or if the therapist is nonnative.” As one key informant explained, in one area African American, or Black, residents are traveling to a provider outside of their neighborhood in order to receive services delivered with dignity in a way that they were not experiencing when seeking services from more local providers: “About 65% of the people we serve are African American males, I think that the county is like 29% African American. We’re disproportionately serving the population, and it’s really because of the geography of the [city]. There aren’t resources available on the [specific area of the city]. Those are the zip codes where we become the trader of last resort. Because we operate an emergency room and people asked to come here. It’s not just voluntary cases, about half the people who come her, come here knowing it is a place they will be treated with dignity and respect. So they don’t even bother going to health systems where they don’t have that experience.”

Pursuit of anti-transgender legislation on the national scene is causing harm and eroding community trust in institutions of care. Both homosexuality and gender identity disorder have been used as clinical signs of mental disorder in the last 50 years. While homosexuality has been removed and gender identity disorder renamed as gender dysphoria, conversion therapy practices still exist and hate crimes perpetrated against transfeminine women of color are at an all-time high. In light of this, it is not surprising to find in this research that sexual and gender minorities are apprehensive about accessing BH services. One provider responded in the survey, “Stigma and fear [exists] for all members of the LGBTQ+ community as well as [the absence of] qualified MH professionals to work with this population.” Others reported that some transgender individuals met with discrimination when they did seek help. In one focus group, a Black trans person shared how she was not provided care at a specific facility because she was trans and providers refused to treat her.

“Trans and LGBTQ pop. Generally feel judged and that people not within their culture do not understand their lifestyles and cultural choices. This was evidenced by one of my Trans participants stating their therapist refused to call him by his chosen name and pronouns”

Those who live at the intersection of many marginalized identities may be particularly in need of support. This includes Black, trans-feminine youth who are homeless. In the US, compared to their peers, youth identifying as LGBTQ or transgender are over twice as likely to experience homelessness over the course of a year. Being Black or African American or having multiple marginalized identities is also associated with increased risk of behavioral health challenges, such as disproportionate risk of

“I think that the Black, Transgender population is one of the most underserved populations in Milwaukee. I think that people have NO education around this population. I think people of color in general are not given the same resources as White folks and so when you add other factors like transgender, there are no services. Trans individuals have so many extra needs around medical issues and mental health issues that no one understands. There is an increase of homeless LGBTQ youth and often many of those are trans kids.”

homelessness across the country (Morton, Matjasko, Dworsky et al., 2017; Seng, Lopez, Sperlich et. al., 2012). Wisconsin appears to be no different.

Heightened fears of deportation renders services inaccessible.

Several respondents shared the concern that, “Undocumented individuals are under extreme stress and are very unlikely to

seek services which adds to their mental health concerns.” There is a well-founded “fear of being ostracized or deported.” Added to this, “a key challenge for the undocumented residents of Wisconsin is that they are ineligible to qualify for Medicaid while undocumented yet are increasingly burdened with the consequences of managing trauma.

“Undocumented individuals that are working on becoming documented are being turned away, treated poorly, no translation services available, limited or no financial support, lack of advocates who can assist undocumented individuals navigate the system.”

Stakeholder Recommendations: Address Stigma, Historical, and Emergent Trauma

The strongest theme that came out of recommendations to address stigma, historical and emergent trauma was to center community-driven solutions. Second to this was the emphasis on reducing the BH system’s association with the criminal justice system.

Invest in public education and outreach about the behavioral health system. A strong theme to come through all sources of data was that the system is confusing, consumers are not clear on how

to access it, many are afraid of being left with a large bill afterward, providers don’t know about one another or how to support consumers in navigating the system and social norms that stigmatize MH and SUD prevent individuals in need of treatment from pursuing it—and with good reason. Without a shift in social norms, consumers face the likelihood of the pursuit of treatment resulting in real material consequences in their lives when others interpret this as a sign of being a bad parent, employee or a criminal in waiting.

“And the public generally doesn’t even know what counties do. They don’t know what services are that are provided. So it’s like the best-kept secret, where private providers, they get to advertise and market. Nobody knows what the counties do.”

Prioritize crisis response alternatives that avoid engaging the police and criminal justice system. This evaluation indicates an urgent need for innovation in public safety interventions for individuals facing a behavioral health crisis. Developing alternatives to policing is an important step toward decreasing the disproportionate criminalization of individuals with behavioral health issues, particularly from Black and Brown communities. Survey respondents suggested changing the statute so that law enforcement would be barred from involvement “unless the person is actively dangerous and then law enforcement involvement should be limited, [instead,] expand use of ambulances for transport, allow for detentions on individuals

who are presenting with significant mental health symptoms prior to the development of dangerousness (psychosis or mania without suicidal/homicidal concerns, but need for treatment), and make the statute more useful overall.”

“Our police department should not be the ones putting them in the back of a police car, taking them to a mental health complex or to the hospital. There needs to be a different system in place that will help people in that situation that is more private, that is more sensitive to their issue.”

A recent publication highlights case studies of innovative approaches to limiting police contact. For example, Tucson, Arizona has spear-headed a collaborative model that has successfully decreased the number of psychiatric events in which law enforcement officers need to intervene. They have vastly improved procedures to reduce the time that law enforcement spends on the transfer of custody. As a result, officers spend less time responding to crises and transporting individuals to care or legal proceedings. The participating officers are also trained to conduct transports in a non-stigmatizing manner — one that balances the safety of the individual and the public while limiting the use of restraints and treating everyone involved with respect.

The Tucson model consists of a mental health support team focused on prevention, mobile crisis teams for immediate stabilization in the community, and a centralized Crisis Response Center prepared to address any behavioral health need at any time, located adjacent to other resources, including a mental health court, an inpatient psychiatric hospital and a general hospital emergency department (See Treatment Advocate Center, 2019 for more detail).

Prioritize hiring culturally diverse providers. The focus group data indicates that marginalized consumers want safe spaces that affirm and validate all identities. More representation in the MH field (e.g. providers that look, identify with and speak the languages of residents from various backgrounds). Residents want representation and support from people who can relate to their experiences. Further recommendations on how to recruit and retain diverse providers can be found in the section on workforce gaps.

Offer more services in the community. Behavioral health treatments, including where and how they’re provided, are another part of culturally appropriate care. One person recounted, “I hear directors say that it's hard for some populations to come into the county building to get help. ... So, if a service can be provided outside of maybe the stigmatizing county buildings or therapist office, I think there's more success that way.” People needing services may be more likely to seek them out if they aren’t worried about the social or professional repercussions of being recognized by neighbors. For marginalized communities in urban areas, moving services into the neighborhood was also seen as a priority. Focus group attendees highlighted a need for community centers in Black & Brown communities that promote and center wellness. Changes as small as the decoration and layout of offices were also mentioned as making a difference for the comfort of minority groups.

Don't ask for demographics. It was noted that the request for demographic information raises red flags for undocumented individuals and that of their family members who are citizens. Given the tactic of the Immigration and Customs Enforcement agency of stalking undocumented immigrants outside of places of work and county buildings, one suggestion was to “send workers who can go into the community and offer the help vs. asking them to come to the agencies.”

Challenges Coordinating Services with Sovereign Nations Leaves Gaps for Native American/Indigenous Consumers

Tribal communities and Native American residents were identified as groups facing unique gaps in service access. These groups are forced to navigate policies and funding structures across both tribal and county governments. Each of the 11 tribes in Wisconsin operate their own clinics that ostensibly offer behavioral health services. However, what is available varies considerably, and is based—in part—on how much money the tribe generates on its own, as well as how much money they receive from Indian Health Services. As a result, some tribes contract out to other regional partners.

“But I think our tribal nations are definitely underserved as far as accessing mental health, actually having mental health services, and all the community supports that go around that. Like job placement, medication, management, and things like that.”

The few informants that discussed Wisconsin's tribal communities felt that the adequacy of services across tribes is not uniform. However, they described that the tribes do face challenges that mirror those of

other under-resourced, rural areas in Wisconsin. As with non-tribal counties, at times services are few and far away and when they are in the community, consumers may be hesitant to utilize them for fear of limited confidentiality in a small community. Though there are cultural differences between tribal communities and rural communities in terms of the meaning attached to formal MH and SUD services, shame and stigma seems to affect access for both groups.

Finally, there is a challenge in coordinating care effectively across the BH services situated inside sovereign nations as well as outside of them: “Another barrier is the lack of coordination by county-run crisis lines with tribes. For example, the outpatient behavioral health (tribal) clinic will not receive notice when a client accesses crisis line services, and the crisis service will not schedule follow-up sessions with the outpatient clinic.”

When tribal clinics do provide behavioral health services, those seeking help may face difficult social dynamics. Clinics provide culturally relevant care, but they are also embedded in a small community where confidentiality issues can arise, as in other rural areas. Respondents indicated that due to the unique cultural context of a tribal community, individuals don't seek care within their communities for fear of recognition and don't seek care elsewhere because of the cultural mismatch of services. This leaves many tribal community members stuck in service gaps.

"As Native Americans, we are seeing more effects of the drug crisis trickling down to the young. More children are being removed from their homes, have a higher disability rate than other races, earlier distinguished developmental delays, and resistance for authority in our area. Young teenagers to adults have a hard time accepting help or don't have the family support to receive help. Many are in survival mode and put up common barriers for assistance."

Existing Translation Services Are Insufficient

Translation services are not fully addressing gaps caused by provider-client language barriers. Several respondents highlighted the challenges of connecting to services, when so few are available in a language other than English. "There's accessibility issues because we don't have enough culturally competent and culturally trained Black and Hispanic, Latino, Puerto Rican providers, Asian providers, [and] providers of color to work with people of the same background. We very much have people that want to have providers that look like them. It's very important."

"Now we're having young people coming in as [an] interpreter who speaks fluent and beautiful English, but in the native tongue, very rusty and don't understand the terminology. For interpreter companies who don't speak the language and understand the culture, feel like, oh, these are great interpreters because they speak beautiful English, but they don't know that their native language is poor."

Our interviewees reported that in many areas, non-native English speakers, non-English speakers, and Deaf individuals all face limited behavioral health care options because of the lack, or inadequacy, of translation services. This affects their ability to receive care *at all*, and the quality of the care they receive, even in cases where a translator is available. One man noted, "if you don't have that knowledge and skills to understand the appropriate culture of that person, it's harder to treat that person, especially when you have language barriers involved. Language line; yeah, we have that, but it's not the same as if you have a bilingual [provider] that could speak the language."

Language interpreter testing is biased toward native English speakers. Additionally, interviewees noted the current practices in hiring interpreters biases the selection of non-English fluency. Specifically, it was suggested that the use of English idioms in testing for interpreters' biases licensing toward native English speakers and fails to identify interpreters with adequate skills for understanding the non-English language.

One man working in the MH field across rural and urban Wisconsin observed, “[Very] good interpreters are the interpreters that come to the United States when they're a teenager, so they speak both languages equally. In the testing process, the challenge is that if I don't live here, I don't understand all the idioms here, so those are on the test. ... [So] therefore I'm not going to pass the test at all because I am being measured as if I was someone who grew up here.”

Sourcing interpreters from within a close-knit community presents confidentiality concerns. One consequence of a limited culturally matched workforce is that it can be hard to find providers or translators without intimate connections to the consumers. In addition to coupling with stigma about seeking help to create a barrier to treatment, this also raises real concerns about the ability to maintain a truly confidential environment. “Among the Asian and Hispanic communities, because there are few providers familiar with the language and culture, most clients feel that everyone will know their private issues. There is a strong feeling of non-confidentiality.” In reference to all non-English speaking consumers, respondents repeatedly described how interpreters who either judge the consumer or are unable to honor confidentiality are a barrier to accessing existing services.

“We have a large Hispanic population in our area, and they are very close-knit. So finding local translators is difficult because they do not want to be involved in such personal information about those they are close to in our community. Bringing a family member or friend is sometimes done, but then again, they are putting that other person in a sensitive position and perhaps they are not as honest and open as they would be if they were able to speak freely to the counselor.”

The dearth of diverse providers and/or translators may result in longer wait times for non-English speakers. This combination of barriers was described by focus group participants as an unseen burden of labor and at times still resulted in services that were not a good fit.

“Cuando tuve mi ultima niña me dio depresión post-partum. me tardaron casi un año para poder encontrarme alguien que pudiera verme. ...esa persona no era psicóloga, era una consejera porque no había alguien que también hablaba español, y eso. Me vieron dos meses y enseguida me medicaron [aunque] dije que no quería depender de eso.”

“When I gave birth to my youngest daughter, I got postpartum depression. It took me almost a year to find someone who could see me. ... that person was not a psychologist, she was a counselor because there was no one who also spoke Spanish, and so on. The counselor saw me for two months and immediately put me on medication [even though] I said I did not want to rely on it.”

Stakeholder Recommendation: Improve Access for ESL and Non-English Speakers

With community guidance, revise the translator certification process. In the focus groups, participants emphasized the need for adequately trained interpreters that provide culturally responsive, accurate, and clear translation for MH services. Residents who do not speak English prefer to receive care in their first language. For individuals who are Deaf or Hard of Hearing, they want to be able to navigate MH services and express their experiences without losing information in translation. Given the feedback that current

translation is not matching the needs of consumers, it makes sense that adaptations to the process of screening potential translators would be most likely to be effective if those who will utilize them are consulted and have a role in shaping the process.

Make translation services reimbursable or provide grants to cover the costs of hiring a translator. Focus group

attendees suggested that

interpreters should be readily available to ensure people can effectively communicate to providers and other staff. Survey respondents identified the financial cost of the translator as a barrier that was preventing outpatient providers from serving deaf, hard of hearing, and/or non-English speaking consumers. One option is to increase Medicaid reimbursement rates for BH services provided to individuals in need of translation, to allow financially strained providers to cover their costs.

“Some OP clinics don’t offer to provide interpreters due to the clinic being responsible for the cost, so there is no profit to the session.”

Give priority to finding bilingual providers rather than relying upon translators. A handful of respondents expressed that even when there are interpreters, the quality of the services is hindered due to the back and forth communication between three parties. They subsequently emphasized that the therapeutic quality would greatly improve if there were bilingual providers as opposed to translators. One respondent pointed out that even when a provider is bilingual, there can still be cultural misunderstandings. There were some comments on practitioners being bilingual, but not culturally fluent or had a better understanding of English than the client’s native language. There was some acknowledgment that this wasn’t just a behavioral health phenomenon, but also a larger service issue in the healthcare system.

Help Deaf and Hard of Hearing mental health service providers obtain their license(s) in Wisconsin. As one provider described, “they are experiencing barriers regarding Wisconsin not accepting out of state clinical hours or training. Also, there is a shortage of individuals/facilities who can provide direct supervision in ASL to those who need their clinical hours. Lastly, if a deaf service provider wants to earn her/his clinical training in a facility, there is an issue with

who will provide and pay for interpreter services since there is no one who can provide the direct supervision in ASL.” The issue of locating the necessary supervision to complete the

3000 hours needed to attain licensure was identified elsewhere as contributing to the loss of qualified professionals with roots in Wisconsin.

“Several Deaf professionals who have graduated with their MSW have struggled to find access to interpreters to complete required training hours to obtain a license to work. All of the Deaf people I know in the field have left our state to find employment.”

Adapt outreach materials and services for a variety of audiences of various literacy levels. Focus group participants suggested there is a need to promote the value of MH and SUD services with a focus on

tailoring materials and services for older/newcomer generations and for youth/1st generation. One idea highlighted by participants was to “incorporat[e] videos and pictures in order to provide those whose first language isn’t English to have more opportunities to express themselves.”

Employ community members to engage in public outreach and support system navigation. Across data sources, there was a sense that more education that focuses on where and how to access services (procedural) as well as learning about what MH entails (health and wellness) is necessary. Moreover, it was emphasized that this education for the general public needs to be culturally sensitive and responsive to different populations. Both focus group participants and survey respondents highlighted this as an opportunity to incorporate and employ peers from and in those communities to develop and conduct public education strategies and communications regarding the BH system.

Knowledge of Marginalized Populations is Limited to the Margins of the BH System

Broadly, key informants seemed to have limited knowledge of the challenges facing marginalized populations, except among individuals for whom it was part of their job description. For example, many key informants knew that African American and LGBTQA populations were underserved in general but didn’t necessarily have much information on why or how. The sentiment “I don’t have much more on that,” was repeated more than once after a respondent made a statement regarding these two groups. Others were knowledgeable about the issues surrounding the LGBTQ and African American populations and the larger pervasive structural inequities. However, across the board, solutions to the barriers facing these groups were not common or definitive.

One possible explanation is the breadth of the issue for these two particular populations statewide. The pervasiveness of the issues they face might require larger efforts by the BHS and healthcare systems that are beyond the scope of individual providers’ experiences. One interviewee described, “I think we do little bits and pieces of it in the state to try and promote it, but I think it would really take a systems-level collaborative effort because I think it happens not just in the behavioral health system but in every system that is in our state.”

For other marginalized populations, such as consumers identifying as Deaf or HOH, informants and respondents who thought to mention their concerns had solutions in hand. So too with tribal communities and LatinX communities. It may be that challenges facing African American and LGBTQA communities are gaining increasing national attention over the years, such that an increasing number of people are aware that there is something there to be concerned about. But unless they are personally charged with addressing it, they are less aware of how to meet the behavioral health needs of these marginalized communities.

Stakeholder Recommendation: Address Limited Knowledge of Marginal Populations

Make cultural competence and humility part of provider training, with a focus on equity issues. Hiring and retaining a diverse workforce is a key part of providing culturally appropriate care, as discussed in the section, “Develop Workforce and Workforce Diversity.” However, providers of all backgrounds should be prepared to support clients from minority groups. One person suggested tackling this from the training side, saying, “I think we could do better with graduate medical education programs. ... [Residency] programs within underserved communities, or minority communities, or American Indian communities, where they can have rotations within those communities and have a more robust experience of providing services beyond dominant society.” These recommendations were also raised by participants in the focus groups: “I really think more emphasis on cultural humility could definitely be something that would help as far as diagnosing and what you need for different populations.” And specifically, that changes to training before entering the workforce are key, “these psychology and counseling programs need to change their curriculum to fix this issue.” While accountability mechanisms to ensure cultural humility in the workforce were recommended by focus group members as a complement to adapted graduate training.

“There’s a lot to say for learning on the job for sure, but I think tribes would say we get a lot of that. I think a lot of underserved communities will say we get the people who don’t know and they’re practicing on us and they’re learning on us.”

However, this recommendation needs to be tempered by the lived experience voiced by

members of tribal communities. There were concerns expressed that recent graduates not from tribal communities could do more harm than good and that tribes do not enjoy being someone’s learning ground. As such, steps need to be taken to develop cultural humility and to invest in pipeline programs into the profession for members of tribal communities to fill the needs of providers themselves.

Lack of Protections and Accommodations for the Working Poor & Caregivers

Access to the system is more challenging for consumers who do not have established care with a primary care provider. A theme that emerged from the hypermarginalized consumer focus groups was that trying to access MH services are difficult if residents are not eligible, do not have a specific insurance, or do not have a referral from a provider. Additionally, specialized services have limited resources and cannot offer support for residents as needed.

“[Everybody] don’t have a primary doctor or care physician, so if you don’t have that, ... that’s the only way you’re going to be able to see a psychiatrist, so that’s what I don’t like about the system.”

There are insufficient protections for workers who need to take time off to access behavioral health services, for themselves or their family. A notable barrier highlighted by a provider in the survey is the inability for many consumers to take time off of work in order to receive services. Others noted that in addition to lacking the flexibility to attend appointments or care for family members, many consumers fear how their employers will treat them if they learn their employees are in treatment for MH or SU support, given the stigma associated with MH and SU challenges.

“The biggest hurdle that I see in our facility is that we are largely a manufacturing county and because of that, employers don’t give employees the time off of work to make outpatient visits because they know they can replace them easily. We see a lot of people who are struggling because they want to get help, but every time they leave work, it’s an unexcused absences that counts against them. Too many and you’re gone. This applies to both adults who are trying to seek treatment for themselves as well as parents who are trying to seek treatment for their kids. The employers don’t care if the child needs to make these appointments, they care if the employee is missing work.”

Single parent households are particularly vulnerable to the lack of worker benefits. The consequences of missing work were noted as particularly difficult for single parent households: “A lot of single parent households see this as a huge hurdle because if you are the only working parent trying to provide for your kids, you can’t afford to lose your job - now you have to choose - get your child (or yourself) treatment, or be unemployed trying to figure out how to pay bills and eat. It’s not a good situation.”

The absence of family-friendly residential treatment marginalizes adults with young children. Parents and families face unique challenges in behavioral health care and require special consideration. For all services, but residential services especially, lack of childcare was cited as a major barrier to access. If caregivers of young children must travel to providers to get treatment, having “childcare at the places where treatment is happening so the parents don’t have to make a choice of staying home with no childcare or making appointments,” would help to reduce this inequity. One person noted that, “Sometimes, parents will avoid

“[You] create scenarios where the most disadvantaged families have to travel the furthest in order to be here. ... [If] we don’t have capacity here, they have to travel quite a long way. Where if they have a commercial plan, there are many more options for them. So I mean, its barrier upon barrier for these types of kids to get the help that they need.”

treatment out of fear that their children will be removed by the Child Protective Service system, or just the practicality of, ‘I’m raising a kid. I can’t really spend a few months in an adult-only facility.’”

Current no-show policies held by private outpatient providers penalize adults with young children, especially when they are low-income and/or isolated from extended family. Patients without reliable transportation and with competing priorities—like childcare, education, or a job—are more liable to be late for appointments or miss appointments in the context of outpatient care. Several interviewees highlighted the tension between these understandable barriers for consumers and the fundamentally limited capacity of

providers. One person observed, “[There’s] a lot of no-shows. So, you may actually have the capacity to serve people, but you can’t double book because what if they both come in at the same time?” Another interviewee noted how organizational policies around no-shows can push out low-income individuals without reliable transit. Some agencies have a “three strikes and you’re out” policy which bans consumers from that agency regardless of their reasons for missing appointments. As a result, their access to services tightens and their condition can worsen. Navigating this tension on an organizational level is an important facet of the conversation around access to care.

“People with mental health miss appointments or don’t give 24-hour notice, they no longer seen. With people dealing with health issues and mental health issues, they do not always have 24-hours notice, just like the rest of us, you don’t know you will wake up sick in the morning.”

Stakeholder Recommendation: Reduce Health Inequities Created by the Lack of Protections and Benefits for the Working Poor

Advocate for legislation that mandates worker protections. Although this is outside of the realm of the BH system, it is clear that the environment in which the system is operating has an enormous influence on how the system functions and in particular, when and how gaps become predictably and inequitably distributed. Given the commonly held sentiment that MH and SU needs are the symptoms of a stressful environment, addressing inequities in the system means leveraging influence to advocate for legislation that reduces stress on Wisconsinites. Stressors regarding work and housing are two of the biggest areas repeatedly noted across types of data collection.

“Develop legislation for employers to allow paid time off/flexible scheduling for medical/MH care of clients.”

Revise the rules for telehealth to allow consumers to receive services from home. A number of respondents and informants were interested in finding solutions that eliminated the need to travel at all for parents with children. One way to do so that costs less than sending a provider to the caregiver’s house is to broaden the rules around the use of technology for treatment. To allow for such services in an uncontrolled environment in the home via a screen, any new telehealth rules may also need to ensure the maintenance of consumer confidentiality protections.

Ban the practice of reporting pregnant individuals with SU concerns to CPS when they seek prenatal care.

This practice is unevenly executed, with mothers of color facing this penalty more frequently than white mothers. This practice is not state-mandated and deters help-seeking behaviors, which are ultimately in the best interest of the child.

“Eliminate child abuse provisions for pregnant substance-using women to remove deterrent for seeking prenatal care.”

Include family members in the treatment process. On the Wisconsin Department of Human Services webpage for MH services, including family members in the treatment process is one of the four signs of a quality program. Yet survey respondents highlighted a continuing need for intentional inclusion of family in the treatment process, to address underlying issues and accommodate the demands of caregiving. One wrote: “Family involvement in most treatment episodes with clients is nearly non-existent in many agencies yet they say that disorders [are] a ‘family illness.’”

Specific suggestions included ensuring that NEMT will transport consumers with young children and earmarking funds to provide supportive services for caregivers of children. Respite services for families were highlighted as a promising strategy for reducing system involvement. A number of providers suggested that at times families involve law enforcement or the BH system just to get a break and if other options were available this could reduce the strain on the more intensive services.

County Levy System Exacerbates the Health Consequences of Segregation and Income Inequality

The consequences of relying heavily upon county tax levy funding has implications on the equity of county BH system resources. Specifically, respondents noted that counties with relatively low tax bases have greater challenges and fewer resources to address these challenges.

Respondents and informants called for the development of cross-county resource sharing and more consistent funding streams, to relieve some of the financial and administrative burden on less populated (and less resourced) counties. One man working in the MH field across rural and urban areas argued, “[There] needs to be some uniformity established in the implementation of MH programs across the state. We have people that move from one county that are involved in a program and they go to another county - that program may not even exist. It may be operated entirely differently. And while no one is going to disrupt this strong county rule in Wisconsin, I think that there has to be some sort of negotiated framework for improving on what we have today.” A person working in outpatient services made a more radical suggestion: “We’re a state that is very much divided up by our counties, and our counties administer some of the dollars available for SU and MH services. I believe we need to move to ... where the state coordinates access to services.” Some form of resource sharing, whether through statewide integration or cross-county coordination, could be a critical step toward increasing access to services.

Stakeholder Recommendations: Reduce the Impacts of the County Levy System on Health Inequities

Explore the possibility of sharing resources across regions. Many generally spoke of adopting a hub-and-spoke model of care while more specific suggestions included neighboring models that have been perceived to be successful such as the “Minnesota model of state coordinated BH services,” and a “statewide comprehensive primary care contract to pay for integrated BH services in primary care. Kansas did this via a partnership between Medicare, Medicaid and Blue Cross Blue Shield to cover integrated BH services at the

University of Kansas Health System.” Others suggested the adoption of “Modern Contemporary Regional Mental Health Centers, which are funded and operated by the State of Wisconsin.”

Insufficient Community Input in Services

Wisconsin’s communities, both rural and urban, are made up of people with diverse identities, backgrounds, and experiences. On an individual, organizational, and community level, this diversity

contributes to different perspectives on health, treatment, recovery, and communication. Concerns were raised that without community input in service approaches and state-level behavioral health strategy, the care that is available ends up missing the mark.

“[Let] the community be a part of your solution so that way you don’t have to shoulder all the headaches and trying to solve a problem that is not yours and you don’t have a full understanding of it.”

One interviewee working in rural Wisconsin highlighted the lack of input from certain communities to the approach to care, linking it to the ways that organizations

develop and implement programming. She argued, “[How] often do you see somebody come in and say, ‘Well, this is what the expert says, and this is what we’re going to do. We wrote up a grant, and we’re going to launch this.’ And there’s been no input from the communities it’s invented for.” The lack of community input in behavioral health services contributes to gaps in culturally appropriate care around the state.

“[We] have our [behavioral health] system that’s so individualized that when you apply the system to the circular thinkers, it harms them rather than helps them.”

Addressing cultural appropriateness was one critical step for respondents to reach more people in need and provide better quality services across the state. But many also felt there was a need to go further, involving those affected by mental illness and in programmatic and state-level decision making. Bringing marginalized populations into the decision-making process is a best practice in the work to advance health equity. This includes approaching

consumers with the dignity they deserve and re-organizing decision-making bodies and processes so that the voices of those most impacted by the gaps in the system are given greater weight and their solutions a higher priority.

“[Nothing] about us without us. I think if I were going to say one thing that would make a huge difference with the cultural responsiveness, is that no program would be approved or funded that did not have large amounts of input from the communities that are targeted or that have been chosen, or that have asked for this service.”

Implications: The Consequences of Inaction

Across all of our data, stakeholders felt that inaction would worsen existing health outcomes statewide, deepen existing health inequities, and perpetuate the intergenerational transmission of trauma.

If the current shortages in psychiatrists are not addressed, the gaps in medication treatment will widen.

As the current workforce retires, the concern is that with current rules regarding medication monitoring, consumers will experience significant gaps in their medication treatment: “If a person’s psychiatrist leaves the practice or retires the person in need is often left with less than a 60 day supply of their meds and the task of finding a new psychiatrist. Once they find a new psychiatrist accepting new people the wait time is often 6 months by that time the original meds have run out and no provider will refill until the new psychiatrist provides a new order. This can leave a person without their necessary meds for over 4 months.”

Behavioral health and criminal justice disparities will worsen without addressing the effects of

institutional bias on Black and Brown communities. If people with BH crises continue to be diverted to the criminal justice system, there is concern that the disproportionate incarceration rate of black and brown residents will continue to grow. Without transitional services, the belief is that the trauma caused by experiences in the criminal justice system will become the burden of the next generation to manage.

Without shifting the focus toward prevention and early intervention, conditions and costs will escalate.

The lack of enough quality services that address BH needs before they become acute puts the BH system in an ongoing crisis mode itself and has serious implications for taxpayers as well. When the BH system does have the capacity to meet everyone’s needs, too many people end up waiting for services or abandon hope to get help. Conditions for a portion of these individuals eventually become acute and they end up in expensive inpatient placements which is an extra cost to taxpayers that could have been avoided. One respondent described the relationship between Family Care organizations and the county BH system as an example of this dynamic: “The Family Care organizations are allowed to limit services to clients which causes crises and then the counties are liable to pay for very expensive inpatient institutions until the person is stabilized enough to be released. They are required to re-enroll in the Family Care [Managed Care Organization] and the cycle begins all over again.”

“We need to put effort into identifying root causes and providing prevention/early intervention, if possible. However, those who are incarcerated, or justice involved have a higher likelihood of co-occurring needs and are often times the least likely to access those services. They are also likely to be parents and without proper care will pass trauma along to the next generation. Identifying root causes within our justice involved folks can decrease the intergenerational patterns.”

Priorities for Change in the Behavioral Health System

Both interviewees and survey respondents were asked to reflect on their suggested priority areas for improving the BH system. The interviews included many State staff and their priorities centered on improving funding, addressing the statutes that govern care, and addressing the gaps in the diversity of providers in order to address equity. Conversely, local outpatient providers, administrators and advocates focused more on improving access to services. Finally, priorities suggested by consumers in the focus groups centered on addressing the mechanisms of marginalization in the system.

As noted by the World Health Organization, “a characteristic common to groups that experience health inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is lack of political, social or economic power.” Thus, they instruct: “to be effective and sustainable, interventions that aim to redress inequities must typically go beyond remedying a particular health inequality and also help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships (WHO, 2020).” As such, this analysis prioritizes recommendations that address these root causes of health inequities and invest in the leadership of marginalized groups.

In this section, we explore the priorities outlined by survey respondents, with expanded detail on the priorities that were consistent across data sources. Following the theory that the absence of a voice and a vote are partly responsible for the existence of predictable health inequities, and that those closest to the problem are those closest to the solution, this report concludes with a section uplifting the voices and solutions offered by those most likely to slip through the gaps in the system. The intersection of the solutions offered by those most impacted and the wisdom of those who work within the system will illuminate the most equitable and viable solutions to the gaps identified.

From the Voices of Those Most Impacted: Strategies for Advancing Health Equity

Groups most impacted by the gaps in the BH system identified by the range of participants in this gaps analysis include in no particular order: people age 25 and younger, the elderly, members of sovereign nations, Black and African American individuals, LGBTQA and Transgender and gender nonconforming individuals, refugee populations, LatinX populations, the deaf and hard of hearing, the homeless, the working poor, people with caregiving responsibilities and people that sit at the intersections of these identities qualify as the hypermarginalized (e.g. elderly black, transfeminine and homeless).

Residents not being able to get MH services is indeed a problem that needs to be addressed. This barrier, however, also creates opportunities for people to come up with their own ways to handle or manage their MH without subjecting themselves to additional harm from an institution. This section explores the

recommendations identified by the consumers who recruited for their membership to historically marginalized communities to participate in the focus groups.

Allowing spaces for people to share their experiences is in itself an important first step; one that needs to be followed with community-driven changes. While some people do not know how or where to access services, others are choosing to forego services they know will not help them. They are actively making decisions about their care because of the lack of care that is offered. Creating alternative ways of healing is also known as self-healing power and is a valid approach for many residents in Wisconsin.

In the focus group space, some residents also shared wanting groups to be able to share their stories. Sharing stories is a powerful way to build trust and understanding between individuals. Further, storytelling is an alternative/ nontraditional approach for processing emotions and feelings that gives support for many.

Prioritize crisis response alternatives that avoid engaging the police. Reducing the involvement of the police when consumers are in an escalated state will require a significant amount of innovation but given the disproportionate involvement of police when the consumer is a person of color, manifesting alternative approaches is an essential step for advancing equity.

“Our police department should not be the ones putting them in the back of a police car, taking them to a mental health complex or to the hospital. There needs to be a different system in place that will help people in that situation that is more private, that is more sensitive to their issue.”

Prioritize hiring culturally diverse providers and invest in services provided in the communities. The focus group data suggested that residents want safe spaces that affirm and validate all identities and clinics that are located in communities of color. Specifically, community centers in Black & Brown communities that promote and center wellness. More representation in the MH field is needed (e.g. providers that look, identify with and speak the languages of residents from various backgrounds). Residents want representation and support from people who can relate to their experiences.

Expand and support a broader view of mental health services. Just as many key informants and survey respondents identified, the current approach to MH services might benefit from a broadened understanding of the various ways in which different cultures have fostered resilience over centuries of adversity.

“Just talking about the positives of mental health and how seeking help for mental health in various ways can be very healing and moving away from a stigma, moving away from the negative of it, but making it more positive, making it more accessible.”

Mental health services should be broadened to encompass alternative forms of counseling and healing. Nontraditional and non-intrusive treatments like storytelling should be incorporated into MH services

offered. Mental health services should aim to have consumers be partners in their understanding of MH and managing mental illness.

Focus group participants emphasized the need for a more holistic viewpoint on MH to be promoted and valued. Residents want MH integrated in schools, workspaces and other spaces of everyday life so discussing MH is normalized. Mental health services that are integrated into other services and accessible for all, and not just for those in a crisis (e.g. preventative services).

Additionally, according to the focus group data, residents want peer support groups in multiple languages. With a focus on educating each other about what MH is, how to access services and what to expect. Residents want support groups that are specific to people's experiences (e.g. substance abuse, alcoholics, parents of children with special needs). This finding is aligned with recommendations heard from the key informant interviews.

Investment in community members, community-based and local organizations to provide services to clients they serve. Financial resources should be given to community-based organizations and community members in order to develop and support meaningful ways to engage MH conversations. Giving resources and allowing community members to make decisions about services needed can increase support for residents who need MH services in meaningful ways.

Equitably restructure access to mental health services and programs for residents. In light of the experience that people with the least wealth have the largest barriers to receiving care that the current BH system does not compensate for, the suggestion was raised that future reformations take issues of equity into consideration.

Training and accountability for current mental health providers. Providers need to be educated in order to serve people across cultures. Interpreters are necessary and need to provide culturally responsive and accessible services for residents. Providers and interpreters should be trained and knowledgeable about MH across various cultural contexts and sensitive to the lived experiences and histories of different communities in Wisconsin. Many residents believe that it's the state's responsibility to actively fight against discrimination. They want accountability for clients who are using services to ensure they are treated with dignity and respect. Residents want quality and timely services for their MH.

Invest in addressing the social determinants of health. Many focus group participants discussed how other stressors impacted their lives and subsequently how they understood their MH. Some saw having access to resources like food and housing as being a solution that

"[If] I had just random money to give away, it would be to create stipends and the ability to financially support and compensate just peers, parents, and young people who have lived experience, who can be a consultant and support these service providers and support the state health department, all that stuff. So that decisions can be made organizationally and from that lens also being informed by the perspective of what they experience."

would improve their overall MH. Having basic needs met are essential to ensuring that people are able to take care of their MH. Accordingly, focus group participants highlighted the need for a wider range of services available for their overall wellness (e.g. food stamps, support for people who are aging).

Community members want opportunities to talk to legislators about services and provide guidance.

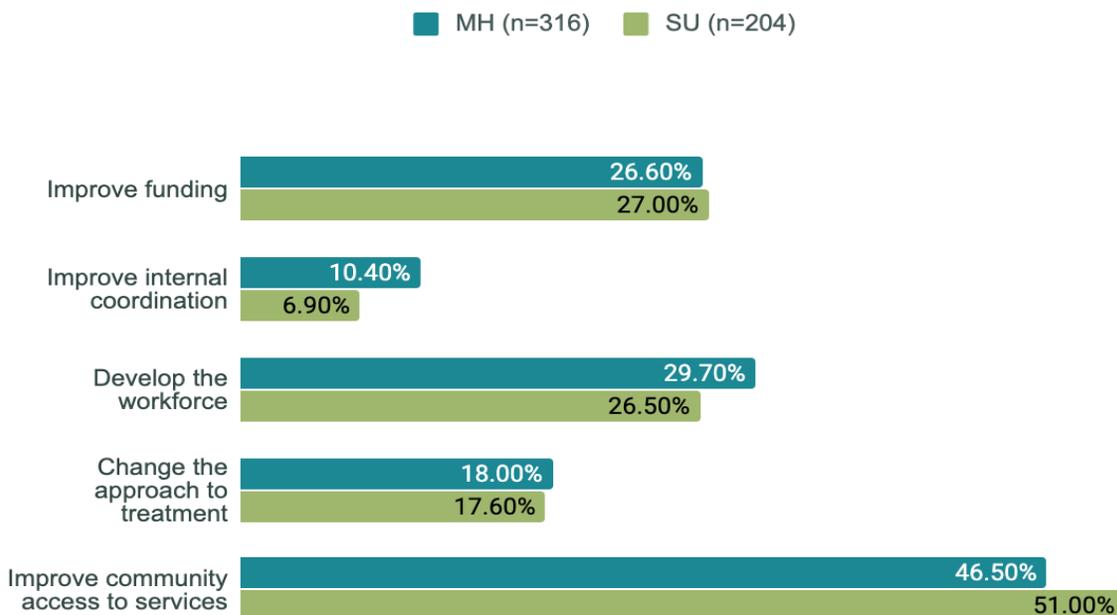
Residents are engaged and concerned about the current state of MH and SU services and interested in playing a defining role.

Themes in Suggested Remedies of Gaps by Survey Respondents

Survey respondents were provided two open-ended questions and prompted to share suggestions for improving the array of MH/SU services and then asked to provide their top recommendations for change. Written responses to each question were coded and thematically categorized using the same categories as there was considerable overlap in responses to each question. Responses to the recommendations question were then quantified by category and patterns are displayed in the graph below. Detail on the themes that emerged more strongly across both questions are summarized below. When appropriate, overlap with key informant and focus group participant data are noted.

As Figure 14 illustrates, the vast majority of priorities identified by survey respondents centered on improving access to the system. The spot for second most frequently endorsed category of solutions was a

Figure 14. Recommendations for Prioritization from Survey Respondents



tie between increased funding and developing the workforce. The third most frequent recommendation was to change the approach to MH and SUD treatment and finally, to improve internal coordination of services.

#1 Increase Accessibility

Increasing accessibility was a category that encompassed a variety of recommendations including: spread awareness of how to access services, locate more services in the community or invest in innovations that bring services to people such as telehealth; improve crisis and detox services; provide more wraparound services to support individuals through transitions in services; change rules to allow in more providers; change rules to allow in more consumers; improve coordination with private insurance; make more affordable for consumers; and reduce waitlists. Below, the recommendations that triangulated across data sources and spoke to root causes of system barriers identified by key informants and survey respondents are prioritized.

Hire community-based system navigators from marginalized communities and the pool of peer specialists to perform outreach and referral services in order to increase access to the behavioral health system among underserved communities.

Reduce geographic barriers by providing more services within the community. A wide variety of recommendations were provided for addressing the issue of physical access to services. The main theme among them was the desire to get resources to people where they are, rather than rely upon identifying ways to get people to specific services. All the suggestions emphasized the value of providing resources to people early to forestall more expensive intensive services later. Suggestions ranged from in-home therapy programs, drop-in community-based wellness and recovery centers, sub or mobile sites, capitalizing on telehealth for group counseling, situating providers in existing organizations such as schools, local churches or homeless shelters; and replicating the ADRC model for crisis prevention using “options counseling, caregiver support, etc., before a crisis happens.”

Prioritize crisis response alternatives that avoid engaging the police and criminal justice system. Noted as serving as a mechanism of inequity, a source of emergent trauma, and a deterrent to health seeking behavior from communities facing disproportionate contact with law enforcement, identifying solutions to reduce reliance upon police contact would increase system accessibility.

Increase intensive outpatient services for consumers in transition. A common concern was the absence of follow through for consumers new on the path of recovery and for those in transitional spaces such as switching between components of the service array or transitioning out of incarceration/detention. For SU services, sober houses and halfway houses were identified as one missing piece of supporting long-term recovery, especially when transitioning out of more intensive environments and back into the community.

Increase availability of youth full-day treatment and overnight respite for families. These priorities were uplifted primarily to address the need for maintaining the close caregiver relationship between parent and child while providing important time-outs for families to avoid escalation into a crisis. It was emphasized that full-day treatment is preferred over half-day because some parents' work schedules disallow them from being able to secure this treatment for their children.

Offer SU support groups in a variety of languages. A few focus group participants shared how having support groups that were specific to the issues they faced would be beneficial. Moreover, having these support groups offered in Spanish and other languages would allow residents to share how they feel in their language and not be limited to English-only groups.

Reduce wait lists by broadening the array of professionals allowed to be reimbursed. Utilize peer specialists, LPCs, LMFTs and LCSWs to address workforce shortages and thereby reduce time spent waiting for treatment. One approach to reducing waitlists immediately would be to utilize professionals already prepared to do the work but currently disqualified from reimbursement by Medicaid for doing the work.

#2 Develop the Workforce

Suggestions that fit into this category included: make dual certification required; subsidize costs of education; integrate BHS training into all health system positions; address stigma among providers toward consumers; and focus on recruiting providers for working with special (e.g., specifically marginalized) populations.

Change licensing policies to enable more substance use providers.

Changes to provider licensing, especially provider credentialing, were highlighted as one way to improve access to services and the quality of care. On more than one occasion, the level of complication inherent in the licensing process was noted as a barrier: "Make substance

"Provide a means to cross-train fully licensed MH therapists so they can provide substance abuse treatment and get Medicaid/insurances to reimburse for the services. Right now, WI allows MH therapists to provide AODA counseling however insurances don't agree/aren't reimbursing for it, but the state took away the ability to get ADOA specialty certificate so there is not streamlined avenue for MH clinicians to provide AODA counseling."

use provider certification less complicated. I'm a social worker with a master's degree and I looked into SU provider certification but found it confusing and opted not to pursue it. I also would have had a difficult time finding suitable supervision to get provider certification." Wisconsin Act 262 opened the door to allow more individuals to provide services. However, many interviewees emphasized that the spirit of this law hasn't been realized, as Medicaid reimbursement for SU services is currently restricted based on provider licensing and some feel that licensing is unduly burdensome. One person described, "[If] a MH practitioner is providing AODA services within their scope of practice, but their license doesn't say that they're an AODA counselor, Medicaid is still not reimbursing for that. So, that's a hole that needs to be plugged in terms of

making 2017 Act 262 fulfill its original purpose.” Others, primarily those working in the field, had concerns about the training (or lack of training) these new SU providers receive. One interviewee suggested incorporating hands-on practice into credentialing processes as a quality improvement measure. In all, the prevailing sentiment is to, “streamline the certification and licensing process, but do not cut out the professional requirements [as] there is still a question of professionalism when looking for a qualified provider.”

Train direct service providers in a variety of sectors in trauma-informed care. Professionals outside of the healthcare system have a role to play as well. Interviewees identified a need to bolster behavioral health training (especially trauma-informed practice) for teachers, childcare providers, police, social workers, and others. One respondent suggested making “early childhood education providers more aware of the manifestations of trauma and MH and substance abuse services.” This kind of integration, they argue, would increase access to care while also diverting individuals from the criminal justice system. Additionally, an improved ability to understand trauma and how it manifests across cultures was identified by focus group participants as an important focus for addressing historical and emergent trauma experienced by marginalized communities within the BH system.

“Trauma overall as a public health issue – it is common and impacts many physical health outcomes and is unaddressed.”

Focus on increasing the diversity of providers. Priority providers include those who are bicultural in both white and a marginalized community such as the DEAF AND HARD OF HEARING community, as well as racial minorities.

Address the provider shortage in rural Wisconsin, especially in psychiatry. Suggestions for doing so include pointed recruitment strategies, offering tuition remission, coordinating with schools and hospitals to provide internships in rural areas, offering grants to cover startup costs for new providers to the region and student loan forgiveness programs.

Focus on improving preparation for working with special populations. Specific populations called out in the priorities section included consumers with cognitive delays across the lifespan and especially for treating children and the elderly.

#3 Improve Funding

Closely tied to the ability to develop the workforce is the availability of funding. Recommendations for addressing funding included:

“[Expanding Medicaid] will take a lot of political will and advocacy but improving the funding structure so that people who need care can get it.”

improving pay via increased reimbursement rates; provide grants or subsidies to cover initial infrastructure of services or ongoing overhead issues for smaller agencies; make more provider activities reimbursable (e.g. writing case notes); and make more services eligible for reimbursement.

Increase the Medicaid reimbursement rate for services.

The majority of interviewees directly called for increasing the rate of Medicaid reimbursement for behavioral health services,

“[My #1 priority is] the ability for professionals to earn a good income without having to over schedule appointments. This work is exhausting. Having to cram in appointments to generate enough revenue to keep the doors open results in poor and ineffective treatment.”

and even more mentioned inadequate reimbursement as a cause of service gaps. According to key informants, this straightforward change would have significant positive ripple effects around the state. One interviewee pointed to this as a way to improve workforce recruitment and retention in the public system, suggesting, “I think that if we can get Medicaid reimbursements to equal to a private reimbursement rate, I think that will attract more providers.” Others noted that increasing reimbursement rates may encourage existing institutions to consider innovative approaches to care. This came up in the context of telehealth, when one interviewee noted, “[Telehealth] needs systems, not just health systems but insurers as well. ... [If a hospital is] not going to get reimbursed at an adequate rate for it, they're going to provide that at a loss, then will be less willing to do that. Not to say that they won't, but it becomes a mathematical equation at that point.” Ultimately, according to key informants, reimbursement rates were the key lever for empowering providers to address accessibility, availability, and quality of services. This overwhelming agreement about the root cause of gaps across the state indicates an urgent need to re-evaluate how the state of Wisconsin is allocating funds through its Medicare and Medicaid programs. As one person noted, “[Expanding Medicaid] will take a lot of political will and advocacy” but it is a problem worth tackling “so that people who need care can get it.”

Specific areas that were highlighted to prioritize for increased reimbursement rates were psychiatrist care, outpatient MH and SU services, as well as fee-for-service case management programs like Community Support Programs (CSP) for individuals with serious behavioral health needs. It was suggested that doing so allows companies to offer MH providers and case managers higher salaries and increase staff retention rates.

Expand Medicaid/Medicare coverage. Beyond reimbursement rates, the array of covered services under Medicaid and Medicare is an important factor in patients' access to care. Most interviewees brought up one or more services that weren't covered, or weren't adequately covered, under current public insurance. Some of the services highlighted in interviews include peer specialists providing outpatient services; crisis services provided by tribal clinics, remote psychiatric consultation to primary care, and holistic care like yoga and acupuncture. These suggestions were primarily relevant to Medicaid coverage. The main coverage exclusion mentioned for Medicare was around provision of SU services. As one person noted, "The biggest barrier with elders is Medicare. Once they're on Medicare, Medicare will not pay for substance abuse counseling by substance abuse counselors. ...If I was going to make a change with that, I would have the Medicare requirements for who can provide services match Medicaid." There were also suggestions to expand Medicaid coverage for inpatient psychiatric care and residential services. The state government controls which services are covered under Medicaid, within the boundaries outlined in federal Medicaid policy. Accordingly, consideration of current coverage - and potential expansion of covered services - is warranted. Finally, the burden of covering assessments was an area that stakeholders identified as in need of financial support: "Grants and insurance should cover drug testing as an integrated and research-supported intervention in comprehensive assessment and treatment for all behavioral health settings."

"Let therapists bill for phone sessions!!! Limit them if you must, but it is just absolutely necessary. There needs to be a way for agencies to find methods to pay their treatment providers for all of their non-direct service time. Or you will never grow the workforce you need."

Ensure satellite locations get reimbursement parity with base locations for services. A hub and spoke model for treatment refers to the increasingly common practice of linking specialty behavioral health programs (hubs) with primary care practices (spokes) in order to be able to offer evidence-based integrated medication-assisted treatment options in healthcare settings that best meet individual needs. While many informants and respondents highlighted the possibility of utilizing this model for MH services, one less known barrier to transitioning toward a hub and spoke model is that currently, satellite (or spoke locations) do not qualify for the same reimbursement rate as the hub locations: "Include satellite locations in reimbursement rates for the same facility hospital. We can't get the same MA rate of reimbursement for children's psychotherapy and psychological assessments under MA in our satellite locations as the hospital, so we cannot serve clients in need here."

Make services more affordable for consumers. A key concern raised in focus group discussions and via survey comments was the prohibitive costs associated with services for some consumers. Accordingly, there was an emphasis on identifying revenues to cover the costs of service and relieve this burden from the consumers. Some consumers went as far as to recommend a complete financial restructuring of the BH

"With my experience, I noticed that access to quality MH services is based on how much you can afford."

system to provide free services for all which would eliminate the current inequities. Furthermore, it was noted

that without efforts to address prohibitive costs, the BH system is contributing to deepening health inequities across differences in income.

Identify new sources of state revenue for behavioral health services. Funding is clearly at the forefront of everyone’s mind. Accordingly, there were a number of suggestions for addressing this stressor on the system. One of which is to work with the state legislature to earmark some of the revenue from taxes collected on alcohol sales in order to provide a no-cost inpatient treatment option, regardless of insurance access. Another example offered was that, “all counties put the surcharge for treatment, paid by OWI fines, in a separate account to be used for treatment as the law states. They currently put that money in a general fund and have no idea how much money has been collected by fines or that that money is supposed to be used only for drunk driver’s treatment programming. They also refuse to use that money if someone has insurance. When someone has a high deductible that fund can be used to help drunk drivers get to treatment, but counties will not accept applications for those funds if someone has any insurance.” Another compelling suggestion is to reduce Wisconsin’s prison population and use the cost savings to match Medicaid funds. Despite having the same crime rate, Wisconsin State and County incarceration rate is roughly twice Minnesota’s. The additional cost in GPR is approximately \$500 million/year for DOC (roughly \$100 for every man woman and child in Wisconsin). If that money were used for the 42% State match for Medicaid, it could increase the Medicaid budget by \$1.2 billion/year without any increase in taxes (potentially a reduction in property taxes due to reduced jail costs).

Additionally, it is possible that cost-savings to law enforcement could be recouped if alternative crisis responses were developed. According to a study of law enforcement’s role in transporting non-threatening seriously mentally ill persons, law enforcement spends 10% of its overall budget responding to and transporting individuals in psychiatric crises to medical facilities. The costs saved in covering that officer’s time could be allocated to other budgets to fund alternative, less stigmatizing and more recovery-oriented approaches to crisis stabilization (Treatment Advocacy Center, 2019).

Enforce parity in coverage between behavioral health and physical health. Private insurance coverage also has a role to play in ensuring all people in Wisconsin have access to care. Many respondents identified a difference between de jure and de facto parity in coverage for behavioral health services. One interviewee explained, “Commercial plans do not understand and are not equipped to provide the kind of coverage it takes for somebody with a severe mental illness or a severe disorder to get the level of services that they need. Relapse is a part of the disorder. Becoming symptomatic can often be a years-long process for people who have serious mental illness. So, these things need to be covered if people are going to be able to get services.” Some interviewees suggested increasing state enforcement, since state codes do explicitly

mandate parity in coverage between behavioral health and general health. Another interviewee recognizing the limited capacity of the Office of

“I know that we all like to say there’s parity now. Well, there’s not parity. There is not parity. The contracts that HMO’s negotiate for behavioral health are always at much less of a rate than a primary care rate. And many commercial plans limit the amount of service you can get.”

the Commissioner of Insurance, proposed allocating resources to ensure staff have the time to follow through on parity investigations.

#4 Supplement the Approach to Clinical Treatment

Suggestions that fell into this category centered on the need for a fundamental shift in what treatment and recovery could look like and to use this shift to guide improvements in the system. Across data sources, there was a repeated desire to have a more holistic conceptualization of the consumer as the central agent of their own process. This would include policies that reflect that recovery is nonlinear, the person is embedded in a system that also needs support if treatment is to bring about transformation, and a variety of treatment modalities are valid.

Intensify efforts to build a recovery-oriented system. “Core values within the behavioral health system need to include: valuing the voice of the person; diverse, trained, trauma-responsive, recovery-focused providers need to staff every contact point within the system (from answering the phone to providing services); flexibility within the system to adapt to each person's unique pathway to recovery; and services need to be accessible (variety of times and locations with support services, i.e. childcare).” Include an understanding of the family system in sustaining behavioral health.

“Focus on prevention and working with a family for a longer period of time to ensure they have the tools to be successful. Those that are in and out of the crisis system will return as they [sic] root of the problem has not been identified; why are they involved in the crisis system to begin with and how can we truly support someone until we/they understand the root cause of their needs.”

Focus on preventative services. Many big ideas about how to improve the quality of care across the behavioral health system focused on the importance of taking a preventative approach. As one person put succinctly, “I think because we have the ambulance parked at the bottom of the cliff we forget about the fence at the top of the cliff.” Shifting state resources and attention toward prevention is a clear focus for change, from the perspective of most interviewees.

“[The] inability to provide services at the front end, these are proactive services, routine services... Or the kind of thing where you’re seeing your physician annually, and they ask you about your mental health and substance use, and you actually get the help you need... That the failure to provide that front end care has led to an incredible explosion in people seeking emergency care.”

Early detection of needs was also highlighted as a best practice that could lead to better outcomes and reduce the population in need of more intensive service down the line. For example, “Increased use of preventive services such as infant / early childhood MH consultation is a SAMHSA endorsed prevention approach. “This also includes timely access to needed services: “[Sometimes] we're so slow in getting interventions started that a person really undergoes a great deal of deterioration before we actually get

them satisfactory treatment. ...[If] you catch it early, just like in the rest of the medical community, you catch it early, you typically get better treatment outcomes than if it gets much worse.”

The State BPTR agency tends to focus many of its mental health resources on treatment for individuals with serious mental illness (SMI) or a serious emotional disorder (SED). The federal MH Block Grant funding that DCTS receives drives much of this focus because it prioritizes individuals with SMI or SED and it comprises a large portion of the BPTR budget. A suggestion was made that an increased allocation of state general purpose revenue (GPR) for the BPTR without such restrictions would free up the BPTR to dedicate more funding to mental health prevention and early intervention initiatives across the state. This sentiment of early intervention and education was echoed in the focus group findings, as well.

Counter the stigma that delays help-seeking. Stigma serves as a root cause of health inequities by shaping the worldview regarding whose fault suffering is and who is deserving of help or support. The sooner the view that BH concerns are a sign of defect or criminality, the sooner people will seek support early on in their journey thereby potentially reducing the strain on resources at the county level.

“Making it okay, especially for the younger generation, it needs to be a stigma that it’s okay to get help and there is nothing wrong with you, you’re making yourself better by getting help, so I think we got to work on that.”

Track data on prevention-focused efforts in order to sustain them. The only area in which there was a call for more data collection was in regard to demonstrating the long-term cost-saving impacts of investing in prevention services. One survey respondent wrote: “We need to provide more data to insurance companies that show increasing the amount of prevention services will decrease the amount of hospital services across a life spanned. The cost benefit analysis can increase services and save private insurance companies and Medicaid money while improving less restrictive services.”

Incorporate efforts to address the social determinants of health for consumers. Some highlighted the importance of considering the social determinants of health when strategizing to prevent MH and SU conditions: “Begin to prioritize, with funding, services and programs that impact the social determinants of health, which have roughly twice the influence on health outcomes as clinical services.” Housing, for example, was highlighted in our data and has been a focus of intervention in other communities. SU and mental illness, for some individuals, can contribute to economic and housing instability. Homelessness is also an inherently stressful experience that places individuals at risk of compounding trauma and adverse health outcomes. Further, efforts to address underlying SU and MH issues among individuals facing homelessness have been found to be most effective when they begin by providing safe and stable housing.

Providing the right services at the right time, including preventive care, would require some of the funding and hiring changes described above. Ultimately, though, this shift could reduce the use of more expensive emergency services and unnecessary escalation of care intensity. As one respondent explained, one benefit of expanding housing options is that it may open-up much needed space in inpatient beds: “People are

linguishing in hospitals longer than they should, or they're in the Crisis Resource Centers only for housing. When, if we had adequate housing available, they could be in that housing and we could be serving the next person.”

Coordinate with schools to improve awareness and access.

A key priority area that a large number of respondents mentioned was to more intentionally and actively engage with the schools to both increase

“Suicide among youth is at an all-time high. We need to do a better job in identifying with youth and formulating trusting meaningful relationships so youth can talk about their experiences and MH challenges. In addition, transitional age youth can easily be lost within the system. Helping young adults get on the right track can drastically affect their life projection.”

understanding of the system as a resource, to normalize behavioral health needs and to get support for young people who have behavioral health needs. It was emphasized that the current model of a part-time social worker is not effective in meeting this goal and that a full-time staff member in all schools is necessary in order to have impact. Stakeholder recommendations also highlighted the need to educate school staff about warning signs and how their own implicit biases may be impacting access for youth. Youth suicide was a key concern, and the inadequacy with which it was being addressed was brought up a number of times.

Create opportunities for greater community representation in decision-making bodies executing changes to the BH system. Bringing marginalized populations into the decision-making process is a best practice in the work to advance health equity. This includes approaching consumers with the dignity they deserve and re-organizing decision-making bodies and processes so that the voices of those most impacted by the gaps in the system are given greater weight and their solutions a higher priority.

#5 Improve System Coordination

Themes that fell into the category of improvements to system coordination included: revise the statutes that govern care; integrate MH and SU services (includes co-locating services in community); move to a regional or statewide system; streamline reporting systems and program creation; educate providers on the referral process and available services; provide more oversight and technical assistance to providers of BH services. As summarized by one interviewee, system coordination involves “collaborative discussions and work across the Department of Health Services, Division of Medicaid Services, Department of Safety and Professional Services that license behavioral professionals, and all these other groups to better align the statutory codes, integrated care and funding streams. So that we can broaden access to care across the whole system and remove the silos that are there and increase parity.”

Revise and combine statutes that govern care. The MH and SU statutes were also a common target of recommendations. Broadly, interviewees called for an update to the codes that regulate behavioral health services. One provider explained that “the type of treatment today is not the same type of treatment 30 years ago, but we still have the same statutes back [from] 30 years ago.” They continue, “[We] have to change the statutes to reflect what is changing” in the field. Another person argued, “We need to look at

[our regulations] and say ‘why are we doing that? Do we actually need that?’ So that we can look at making sure that we ... are providing quality service, we are protecting people, but we are not setting up barriers to get employees or to get people ... access.” A thoughtful review of the statutes relevant to behavioral health could be an important step toward modern, effective, and accessible care statewide.

Integrate BH training into all health system positions. There are also key opportunities to improve consumer access by strategically connecting behavioral health to other systems. For example, there is a belief that primary care providers are an important underutilized access point to the BH system. Specifically, it was suggested that primary care providers could be prepared to initiate conversations with patients about MH and SU. One interviewee remarked, “[If] I go see my primary care doctor and say I have a drinking problem, my primary care doctor should know how to respond to that.” This capacity building on the part of doctors has to come with active outreach by SU and MH providers to ensure patients don’t fall through the gaps in the referral process.

Move away from a county-specific funding system. A common suggestion was to move toward regionalizing funding structures, unifying behavioral health data systems, strengthening regional behavioral health coordination and leadership, or investing in hub-and-spoke or telehealth models.

Limitations

Although this gaps analysis of the Wisconsin Behavioral Health System is unprecedented in its reach, representation of perspectives and depth of detail, like all data collection endeavors it is subject to potential bias and thus the reader is advised to interpret these results with caution and a critical eye. This section reviews some potential limitations that should be considered when evaluating the merit of these findings.

The key limitation to this Gaps Analysis is the inability to follow-up with the various stakeholders who contributed their viewpoints to this analysis. It is entirely possible that the questions were interpreted differently by different respondents and that our thematic analysis of their responses did not accurately capture the nuance attempted to be communicated. Without creating an opportunity for stakeholders to respond to this report, the degree of error represented herein will remain unknown.

Furthermore, although the diversity of responses captured in this report is outstanding, there is nevertheless a skew in sheer numbers and in data source. As stated earlier, the survey respondents were over half providers or administrators in outpatient and community services; our respondents were reflective of this workforce in their demographics (e.g., predominantly cisgender, heterosexual white women). Overall there was greater familiarity with the challenges facing mental health services, although a considerable number of survey respondents indicated familiarity with both arms of the system. Keeping all of these factors in mind, it is possible that this report skews toward more accurately representing the needs of the MH outpatient service system, although not necessarily.

In the absence of analyses accounting for unequal group sizes, the reader is cautioned from drawing strong conclusions on comparative need based upon numbers. While percent of cases is provided to support interpretation of the data based upon proportions rather than sheer numbers, the authors were unable to disaggregate by identity, nor run group comparisons of frequency rates. As such, it is not possible to confirm, nor rule out, skewness of the data based upon identity.

Additionally, since the questionnaires were not validated ahead of time to ensure reliability, it is likely respondents did not all interpret the questions the same. There is some evidence to support the hypothesis a standardized understanding of the questions in the survey data was lacking. Specifically, it was not uncommon for participants to enter a response to one question in the open entry “other” option of another question. For example, in some responses to the question, *“What other geographic barriers do consumers encounter when attempting to access medication assisted treatment?”* Some respondents entered “stigma.” While they might be suggesting stigma is only an issue in certain regions, others saved their thoughts on regions with high stigma for the questions regarding culture and stigma. Ergo, the reader is cautioned about making decisions based upon proportionate responses to each question.

Finally, in the key informant interviews respondents at times referred to a service array component such as “inpatient” without also clarifying if they were exclusively referring to MH or SU inpatient services, or both. This is challenging as each service array component in each arm of the system is governed by different constraints and often different funding sources and thus different gaps and barriers. Similarly, in the survey inpatient and residential services for SU were grouped together in one question, ergo this analysis contains limited data that distinguishes between the two in terms of gaps and barriers.

Next Steps

The global pandemic presented with COVID-19 is forcing all systems to work differently and presents the opportunity for systems to work better. Already, legislation expanding telehealth has passed, rapidly addressing access barriers identified in this report. With the gaps, barriers and desired priorities identified, a sensible next step would be to convene stakeholders and decision-makers to capitalize on these unprecedented times and identify the immediate, short, and long-term action plans to address the most egregious gaps and improve equitable access to the Wisconsin Behavioral Health System.

Since the challenges highlighted in this report are by no means unique to Wisconsin, devoting some existing resources to searching the extant literature evaluating the impacts of various interventions seems prudent. For example, other states such as New Hampshire and Vermont have faced similar challenges with long waitlists, workforce shortages, and needed improvements to crisis services, have undergone the process of developing a 10-year strategic plan to transform their behavioral health systems into more effective systems of care and undoubtedly have learned valuable lessons along the way (See NH DHHS, 2019 for a description of the strategic plan development process; see New Hampshire, 2019 for New Hampshire’s final 10-year plan to create a System of Care).

There is also a body of intervention-specific evaluative literature such as regarding reformations to the systematic response to crisis situations for the seriously mentally ill. However, as this literature is quick to caution, a one-size-fits-all approach is unlikely to be appropriate in all regions given the variation in resources and challenges. Partnering with service learning courses at the university to produce literature briefs on interventions to address various priority areas in region-specific ways is a cost-effective way to address this need.

Informed with evidence-based options, convening key stakeholders combined of decision-makers with intimate knowledge of how to effectively enact changes to the existing behavioral health system and people that intimately understand the consequences of current and potential policy and practice changes is essential. This could follow the model provided the State of Minnesota and involve convening representatives from law enforcement, hospital systems, the legislatures, outpatient providers, consumers and advocates and state-level administrators, among others (Wilder, 2017). Most importantly, if the commitment to reduce health inequities is authentic, meaningful resources need to be allocated to promoting the self-determination of currently marginalized groups. Authentic commitment is measured by the evidence of significant budgetary line allocation, the creation of accountability mechanisms to monitor and reduce the effect of implicit bias on system access, and through meaningful inclusion in the decision-making process by Black, Indigenous, and People of Color, among others.

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**2021 Combined Application for the
Substance Abuse Prevention and Treatment Block Grant and
Community Mental Health Services Block Grants**

Executive Summary

DRAFT - July 15, 2020

**Bureau of Prevention Treatment and Recovery
Division of Care and Treatment Services
Wisconsin Department of Health Services**

Background

Federal law requires that each state submit an annual application for their allocation of Substance Abuse Prevention and Treatment Block Grant (SABG) and Community Mental Health Services Block Grant (MHBG) funds. Wisconsin will again be filing a combined SABG and MHBG application for FFY 2021. This year's application is for the second year of two years of funding and programmatic plan. As such, this application is an abbreviated application, reaffirming the comprehensive application submitted in 2019. The deadline for submitting the current combined application to the Substance Abuse and Mental Health Services Administration (SAMHSA) is September 1, 2020. States are instructed to develop the SABG and MHBG plans for FFY 2021 using the 2020 awarded amounts. The amount Wisconsin received in FFY 2020, and is using as a baseline for the development of the 2021 application is \$27,199,453 via the SABG, and \$11,793,459 via the MHBG.

2020-2021 Block Grant Priority Areas

The following priority areas were submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) in the 2020-2021 Application and plan in 2019. These priority areas will continue via the 2021 funding.

2020-2021 SABG Priorities
FEDERALLY REQUIRED PRIORITIES
1. A minimum of 98 percent of all certified Alcohol and other Drug Abuse (AODA) treatment agencies in Wisconsin will comply with tuberculosis (TB) screening, information and referral policies and practices.
2. Increase prevention, street outreach and access to recovery-oriented treatment for persons who inject drugs by at least 2% annually.
3. Increase access to culturally appropriate and comprehensive services for special populations, including Hispanic/Latinos, Native Hawaiian or Pacific Islander, African American, Asians, American Indian or Alaska Native, Lesbian Gay Bisexual Transgender and Questioning (LGBTQ), and veterans.
4. Reduce youth access to tobacco products and maintain at retail outlets a non-compliance rate of less than 10 percent statewide.
5. Increase the number and quality of substance use disorder services targeting pregnant women and women with dependent children.
6. Provide services for individuals in need of primary substance use disorder prevention by spending a minimum of 20 percent of the SABG funds on primary prevention.
ADDITIONAL STATE PRIORITY AREAS
7. Reduce binge drinking for adults ages 18-55 and for youth ages 12-17.
8. Prevent the misuse and abuse of all opiates in Wisconsin in order to reduce the number of opiate-related deaths.
9. Expand interventions and treatments for methamphetamine addiction.
2020-2021 Combined SABG and MHBG Priorities
1. Expand the use of Evidence Based Practices in the Mental Health and Substance Use Disorder service systems.

2. Expand and enhance the workforce capacity for Mental Health and Substance Use Disorder services.
3. Improve the quality and effectiveness of behavioral health services in the criminal and juvenile justice systems.
4. Increase service quality and system capacity through the training, certification, employment, and utilization of Certified Peer Specialists.

2020-2021 MHBG Priorities
1. Expand the provision of Coordinated Specialty Care model services for youth and young adults experiencing a First Episode Psychosis.
2. Improve service outcomes for youth with SED through the use of Coordinated Services Teams (CST) Initiatives.
3. Prevent suicide and suicide attempts in Wisconsin.

Proposed 2021 SABG High Level Allocation

The following is the proposed high-level allocation to be included in the 2021 SABG. There are both federal (see Attachment A) and state statutory requirements (see citations below) for the disbursement of the SABG funding which are included in the block grant documents submitted for review.

SABG FFY 2021 ALLOCATIONS DRAFT	
Community Aids (s. 46.40(2m)(a))	\$9,735,700
State Operations and Administration (20.437(5)(mc))	\$2,219,600
Department of Corrections	\$1,347,417
Department of Children and Families (s. 48.561(3)(a)2, s. 48.545)	\$3,016,000
Women’s AODA Initiatives (s. 46.86, s. 46.55(3m))	\$3,613,348
Juvenile Justice Treatment Grants (s. 48.547(2), s. 165.987(2), s. 20.455(2)(k))	\$1,619,285
Other Primary Prevention Initiatives (s. 46.71, s.252.12(2)(c), s. 6.49(1))	\$2,603,288
Other Treatment Related Grants (s. 46.65, s. 6.49(1))	\$2,922,314
Other Evaluation, Training & Consulting	\$122,501
TOTAL Allocations FFY 2021 SABG (October 1, 2020 – September 30, 2021)	\$27,199,453

Proposed 2021 MHBG High Level Allocation

The following is the proposed high-level allocation to be included in the 2021 MHBG plan. There are both federal (see Attachment B) and state statutory requirements (see citations below) for the disbursement of the MHBG funding which are included in the Block Grant documents submitted for review. The specific state statute references that guide the distribution of funding are included if applicable.

MHBG FFY 2021 ALLOCATIONS	
Community Aids (46.40(2m)(b))	\$2,513,400
Children’s Mental Health/Coordinated Services Teams (CST) (46.56)	\$1,827,000
Family and Consumer Self-Help and Peer-to-Peer Support (46.54)	\$1,531,621
Systems Change (46.52)	\$110,000
Recovery and Early Intervention	\$1,715,000

Redesign, Transformation, and Training (46.53) Activities	\$2,982,379
Wisconsin Protection and Advocacy (51.62(3m))	\$75,000
State Operation and Program Development Costs	\$1,039,059
TOTAL Allocations FFY 2020 MHBG (October 1, 2019 – September 30, 2020)	\$11,793,459

Public Review Required

The federal requirements for submission of the block grants include the review by the state planning council, which by statute is the Wisconsin Council on Mental Health (WCMH). The State Council on Alcohol and Other Drug Abuse (SCAODA) is the appropriate body to comment on issues related to substance use and the SABG. The WCMH and SCAODA provided review and comment on the combined 2020-2021 Block Grant Plan in the summer of 2020.

ATTACHMENT A: Federal Specific Requirements for the Substance Abuse Block Grant

There are federal parameters on the use of the federal Substance Abuse Prevention and Treatment Block Grant (SABG) as noted below:

- States must expend no less than 20% on primary prevention.
- States must expend no less than 5% on treatment services for pregnant women and women with dependent children.
- State can only use 5 percent of the grant for administrative purposes (i.e. processing of contracts and payments and agency indirect costs) with respect to the grant. A portion of the block grant is used for program development activities beyond the 5 percent administrative amount (i.e., staff salaries to implement the federal required program development and quality improvement activities) as established in the State Biennial Budget.
- The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services. Further, all entities that serve women and who receive block grant funds must provide preference in the following order:
 - To pregnant women who inject drugs first.
 - To other pregnant women with substance use disorders second.
 - To other injecting drug users third.
- Grant funds shall not be used to provide inpatient hospital services unless the safety of the patient is in jeopardy.
- Additionally, the daily rate of payment provided to the hospital for providing the services to the individual cannot exceed the comparable daily rate provided for community based non-hospital residential programs of treatment for substance use disorders and the grant may be expended for such services only to the extent that it is medically necessary (i.e., only for those days that the patient cannot be safely treated in a residential community based program).
- Grant funds shall not be used to make cash payments to intended recipients of health services.
- Grant funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment. The Secretary may provide a waiver of the restriction for the construction of a new facility or rehabilitation of an existing facility, but not for land acquisition.
- Grant funds shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.

- Grant funds may not be used to provide financial assistance (i.e., a subgrant) to any entity other than a public or non-profit entity. A State is not precluded from entering into a procurement contract for services, since payments under such a contract are not financial assistance to the contractor.
- Grant funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
- Grant funds may not be used to enforce Federal laws regarding sale of tobacco products to individuals under age of 21, except that grant funds may be expended from the primary prevention set-aside for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.
- No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization.
- The State must maintain State expenditures for community substance use prevention and treatment services at a level that is not less than the average level of such expenditures maintained by the State for the two-year period preceding the fiscal year for which the state is applying for the grant.

ATTACHMENT B: Federal Requirements for the Community Mental Health Block Grant

There are federal constraints on the use of the federal Community Mental Health Block Grant as noted below:

- The primary target groups for the funds are adults with a serious mental illness or children with a severe emotional disturbance.
- The state will provide services only through appropriate, qualified community programs.
- Cannot be used for inpatient services.
- Cannot be used to make cash payments to intended recipients of health services.
- Cannot be used to purchase or improve land, purchase, construct, or permanently improve any building or other facility, or purchase major medical equipment.
- Cannot be used to satisfy any requirement for the expenditure of non-federal funds as a condition of the receipt of federal funds.
- Cannot be used to provide financial assistance to any entity other than a public or nonprofit entity.
- State can only use 5 percent of the grant for administrative purposes (i.e. processing of contracts and payments and agency indirect costs) with respect to the grant. A portion of the block grant is used for program development activities beyond the 5 percent administrative amount (i.e., staff salaries to implement the federal required program development and quality improvement activities) as established in the State Biennial Budget.
- Must maintain a level of spending in the block grant for a system of integrated services for children not less than the amount expended by the state in 1994.
- The State must maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the two-year period preceding the fiscal year for which the state is applying for the grant.
- States must allocated 10% of the MHBG towards early intervention programs for early serious mental illness.

2020 Substance Use Prevention, Treatment, and Recovery Training Sessions and Conferences

Society for Prevention Research 2020 Annual Meeting – “Why Context Matters: Towards a Place-Based Prevention Science”

July 21-23, 2020

Virtual

For more information: <https://www.preventionresearch.org/2020-annual-meeting/>

CADCA’s Mid-Year Training Institute

July 26 – 30, 2020

Virtual

Held for 4 days during the summer, the Mid-Year Training Institute offers in-depth, interactive training sessions geared specifically for community coalition leaders and staff. The Mid-Year also includes two levels of training for the National Youth Leadership Initiative activities (Key Essentials and Advanced). From fundamentals of coalition building and strategic planning to evaluation and research, you will come away motivated and inspired. Hosted by CADCA and for more information: <https://www.cadca.org/>

National Conference on Addiction Disorders

July 30-August 2, 2020

Virtual

Each year, we look forward to connecting with our national community to share groundbreaking and evidence-based treatment strategies, to ultimately improve patient care. In place of in-person NCAD events, we are excited to announce that we will be moving to a Virtual Experience, full of interactive video content, taking place July 30–August 2. For more information: <https://www.theaddictionconference.com/>

HOPE Consortium Training

August 6 and 7, 2020

Virtual

TARGET AUDIENCE: The conference is designed for Providers, Criminal Justice Partners, Human Services, Prevention Professionals and Community and Tribal leaders. Individuals that work or reside within the HOPE Consortium service areas (North Region: Oneida, Vilas, Forest, Price or Iron counties or Sokaogon Chippewa, Lac du Flambeau Chippewa or Forest Potawatomi Tribal Nations and Central Region: Clark, Jackson, Portage, Wood and HoChunk Tribal Nation) are invited to attend. Registration will be \$25 and will include virtual sessions and conference materials.



HOPE Conference
Registration Packet

Registration: <https://hopeconsortium.org/trainings>

5th Annual Wisconsin Peer Recovery Conference – “Thriving Amid Adversity”

August 13-14, 2020

Virtual Conference via Zoom

\$50 Registration fee

Conference Objectives: Demonstrate aspects of effective peer support within community services, enhance individual skills to provide more effective personal support, and explore innovative applications of peer support in communities.

Registration opens June 1, 2020. For more information: <https://www.uwsp.edu/conted/Pages/Wisconsin-Peer-Recovery-Conference.aspx>

Marijuana and Youth: Two Part Series

Friday, August 14, 2020, 8 am to 4 pm

Northcentral Technical College

Wausau, WI

Attend one or both session on the current impact of marijuana, legalization, and vaping on youth.

August 14 – The commercialization and impacts of legalization including cultivation, packaging and sales – Ben Cort, Ben Cort Consulting and the National Marijuana Initiative. The science of THC, CBD, and vaping related illness – Michelle Peace, Virginia Commonwealth University. \$40/session – light breakfast and lunch included. For more information:

<https://www.ntc.edu/calendar/2020/marijuana-and-youth-two-part-series>

4th Annual Rejuvenating Tribal Communities Conference

August 24-26, 2020

Potawatomi Hotel & Casino

Milwaukee, WI

For more information: <https://www.fcpotawatomi.com/event/rejuvenating-tribal-communities-conference/>

10th Annual Prevent Suicide Wisconsin 2020 Conference: Reframing the Narrative

September 8 & 9, 2020

Virtual

Prevent Suicide Wisconsin’s annual conference is tentatively scheduled to be held virtually on September 8 and 9.

Originally planned for April 28 and 29 in Wisconsin Dells, the conference will be held on Zoom to protect the health and safety of attendees.

For more information: <https://www.preventsuicidewi.org/psw-annual-conference>

24th Annual Crisis Intervention Conference – “2020: The Dawn of a New Decade: Innovations in Intervention”

September 17-18, 2020

Virtual Conference via Zoom

For more information: <https://www.uwsp.edu/conted/Pages/Crisis-Intervention-Conference-.aspx>

Wisconsin Society of Addiction Medicine (WISAM) 2020 Annual Conference – “Substance Use Disorders and Beyond 2020: A New Era”

October 1-2, 2020

The Pyle Center – Madison, WI.

For more information: <http://wisam-asam.com/WISAM2020>

2020 Wisconsin Alcohol Policy Seminar

October 8, 2020

Virtual Conference via Zoom

\$75.00 Registration fee

A specialized session on alcohol policy for local officials, law enforcement, coalition leaders, and advocates offering 13 alcohol policy topics in 16 workshops. For more information: <https://www.uwsp.edu/conted/pages/health-and-human-services.aspx>

Marijuana and Youth: Two Part Series

Friday, October 9, 2020, 8 am to 4 pm

Northcentral Technical College

Wausau, WI

Attend one or both session on the current impact of marijuana, legalization, and vaping on youth.

October 9 – The data behind legalization: Including Rocky Mountain HIDTA report trends – Dale Quigley, HIDTA National Marijuana Initiative. The devices: Vaping products and culture trends – Dan Zsido, National Association of Drug Diversion Investigators. The addition: Treatment and recovery – Steven Meerschaert, Brighton Center for Recovery.

\$40/session – light breakfast and lunch included. For more information:

<https://www.ntc.edu/calendar/2020/marijuana-and-youth-two-part-series>

POSTPONED: 13th National Harm Reduction Conference

October 15-18, 2020

San Juan, Puerto Rico

\$385 Registration fee

The 2020 National Harm Reduction Conference comes at a time when harm reduction, health care, and drug policy reform have entered a dynamic and critical phase. The prescription opioid and heroin overdose epidemic has captured national attention, with renewed focus on transmission of HIV and viral hepatitis among people who use drugs. These trends are reshaping the policy and public health landscapes, making harm reduction more urgent and relevant than ever before.

For more information: www.harmreduction.org/conference

Wisconsin's 16th Annual Mental Health and Substance Use Recovery Training Conference – “Thriving in Recovery: Supporting Ourselves and Others in the Journey”

October 29-30, 2020

Virtual Conference via Zoom

For more information: <https://www.uwsp.edu/conted/pages/health-and-human-services.aspx>

Northern Wisconsin Substance Abuse Conference

November 18-19, 2020

Northcentral Technical College

Wausau, WI

This conference is for substance abuse counselors, recovery coaches and advocates, health care professionals, social workers and service providers.

November 18 – Clinical Supervisor Objectives

November 19 – Ethics in the Clinical Relationship Objectives

Registration \$150 both days, \$90 single day – CEUs 12 hours for both days, and 6 hours for single day.

Cocaine, Meth & Stimulant Summit

November 20-22, 2020

Miami, FL

The Cocaine, Meth & Stimulant Summit is the only educational event providing clinical, law enforcement, and public health professionals with practical strategies and solutions to address the country's stimulant crisis. Conference attendees hear from field leaders and change makers working to address this often under-recognized emergency compounding the opioid epidemic. For more information: <https://www.stimulantsummit.com/>

2021

Alcohol Policy: Evidence to Action Building a Framework for Change

April 7-9, 2020

Arlington, VA

The Alcohol Policy Conference series convenes researchers, community practitioners, public officials, faith partners and other concerned citizens primarily from North America. Building on the foundation of the first conference in 1981, this event will continue to emphasize the importance of moving from evidence to action in alcohol policy research, development, implementation, enforcement and evaluation. For more information: www.alcoholpolicy.org



SCAODA 2020 Meeting Dates

March 13, 2020 (Cancelled)

June 5, 2020 (Remotely via Zoom)

August 7, 2020 (Remotely via Zoom)

September 11, 2020 (Meeting Mode TBD)

December 4, 2020 (Meeting Mode TBD)

American Family Insurance Conference Center

6000 American Parkway

Madison, WI

A-Building, Room A3141 in the Training Center

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

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

ARTICLE I

Purpose and Responsibilities

Section 1. Authority

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

Section 2. Purpose

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

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

Section 3. Responsibilities

The state council on alcohol and other drug abuse shall:

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

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

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

ARTICLE II

Membership

Section 1. Authority

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

Section 2. Members

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

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

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

2.3 Selection of Members

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

2.4 Ex-Officio Members

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

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

2.5 Selection of Officers

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

2.6 Terms of Voting Members

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

2.7 Code of Ethics

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

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

2.8 Nondiscrimination

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

2.9 Nomination Process for Appointed Members and Officers

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

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

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

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

2.10 Removal from Office

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

Section 3. Officers

3.1 Chairperson

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

3.2 Vice-Chairperson

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

3.3 Secretary

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

3.4 Vacancies

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

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

ARTICLE III

Council Meetings

Section 1. Council Year

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

Section 2. Meetings

2.1 Regular and special meetings

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

2.3 Notice of meetings

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

2.3 Quorum

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

Section 3. Public Participation

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

Section 4. Conduct of Meetings

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

Section 5. Agendas

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

Section 6. Attendance Requirements

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

Section 7. Staff Services

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

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

Section 8. Reimbursement of Council and Committee Members

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

ARTICLE IV

Committees

Section 1. Committee Structure

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

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

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

It is the intent of this section that:

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

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

Section 2. Composition of Committees

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

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

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

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

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

Section 3. Requirements for all Committees

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

Section 4. Requirements for Committee Chairpersons

The chairperson of each committee is responsible for:

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

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

Section 5. Executive Committee

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

5.2 The executive committee will have the following responsibilities:

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

5.3 Rapid Response

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

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

necessary before a council meeting may reasonably be convened.

ARTICLE V

Amendments

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

