

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

Federal Fiscal Year 2024-2025

The following document is a draft of the bi-annual combined application and plan for the 2024-2025 MHBG and SUBG for Wisconsin. This draft is intended as a first version to solicit feedback and input from the public and members of advisory councils and committees. This application and plan may change from this version prior to being submitted to the Substance Use and Mental Health Services Administration (SAMHSA) on September 1, 2023.

Any public comment and/or feedback can be directed to Sarah Boulton (SUBG Planner and Coordinator) and Hannah Foley (MHBG Planner and Coordinator) within the Bureau of Prevention Treatment and Recovery at [sarah.boulton@dhs.wisconsin.gov](mailto:sarah.boulton@dhs.wisconsin.gov) and [hannah.foley@dhs.wisconsin.gov](mailto:hannah.foley@dhs.wisconsin.gov).

DRAFT August 9, 2023

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# Wisconsin

## UNIFORM APPLICATION

FY 2024/2025 Combined MHBGSUPTRS BG  
Application Behavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024  
(generated on 08/09/2023 10.46.37 AM)

Center for Substance Abuse Prevention

Division of State Programs

Center for Substance Abuse Treatment

Division of State and Community Assistance

and

Center for Mental Health Services

Division of State and Community Systems Development

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NOT FINAL

# State Information

## State Information

### Plan Year

Start Year 2024

End Year 2025

### State SAPT Unique Entity Identification

Unique Entity ID CG2SZ7HCNV54

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

Agency Name Department of Health Services

Organizational Unit Division of Care and Treatment Services, Bureau of Prevention Treatment and Recovery

Mailing Address 1 W. Wilson St., Rm 850

City Madison

Zip Code 53703

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

First Name Teresa

Last Name Steinmetz

Agency Name WI Department of Health Services, Division of Care and Treatment Services

Mailing Address 1 W. Wilson St., Rm 850

City Madison

Zip Code 53703

Telephone (608) 266-2861

Fax 608-266-1533

Email Address TeresaJ.Steinmetz@dhs.wisconsin.gov

#### State CMHS Unique Entity Identification

Unique Entity ID CG2SZ7HCNV54

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

Agency Name Department of Health Services

Organizational Unit Division of Care and Treatment Services; Bureau of Prevention Treatment and Recovery

Mailing Address 1 W. Wilson St. Room 850

City Madison

Zip Code 53703

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

First Name Teresa

Last Name Steinmetz

Agency Name Department of Health Services, Division of Care and Treatment Services

Mailing Address 1 W. Wilson St., Rm. 850

City Madison

Zip Code 53703

Telephone (608) 266-2861

Fax 608-266-1533

Email Address TeresaJ.Steinmetz@dhs.wisconsin.gov

**III. Third Party Administrator of Mental Health Services**

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

**V. Date Submitted**

Submission Date

Revision Date

**VI. Contact Person Responsible for Application Submission**

First Name Ryan

Last Name Stachoviak

Telephone 608-261-9316

Fax 608-266-1533

Email Address Ryan.Stachoviak@wisconsin.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# State Information

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

Fiscal Year 2024

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

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

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

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## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

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## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: Debra Standridge

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Deputy Secretary

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

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## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Debra Standridge

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Deputy Secretary

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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# State Information

## Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

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Name

Debra Standridge

Title

Deputy Secretary

Organization

Wisconsin Department of Health Services

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Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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## Planning Steps

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

#### Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the [Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

#### Footnotes:

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

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

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

As noted above, county mental health and substance use disorder providers use county tax levy dollars to fund a portion of the services they deliver. State and federal tax dollars are also used to fund a portion of mental health and substance use services for public consumers. The largest source of federal funds for the provision of mental health services is through the Medicaid program. In Wisconsin most mental health Medicaid recipients are served through the Badger Care and SSI managed care programs. As a consumer's Medicaid status may change throughout the period of a year and program coverage policies have limitations, some consumers may use benefits through both programs to get the services they need. In addition, Wisconsin implemented SUD residential treatment services in 2021. Also, state general purpose revenue funds have been promulgated to fund several regional opioid treatment centers. DHS also uses other federal grant awards – including Strategic Prevention Framework for Prescription Drugs, Prescription Drug/Opioid Overdose-Related Deaths Prevention Project, and State Targeted Response/State Opioid Response awards – to address substance use disorder needs.

**Psychiatric Hospitalization**

When psychiatric hospitalization is required in Wisconsin it occurs in one of the following five settings: state mental health institutions, county mental health hospitals, veteran's administration hospitals, private psychiatric hospitals, and general medical/surgical hospitals. DCTS has administrative management of the two state mental health institutes: Mendota Mental Health Institute (MMHI), in Madison, and the Winnebago Mental Health Institute (WMHI), near Oshkosh. These facilities provide specialized, acute treatment to children and adolescents, adults, older adults, and forensic mental

health consumers. The institutions provide training and consultation as requested to community-based programs. As an arm of the MMHI, the founding model Program for Assertive Community Treatment (PACT) is in operation, serving Dane County.

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

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

### **Substance Use Disorder Prevention and Treatment Services**

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

Counties are responsible for developing and managing a system of care for persons with substance use disorders (Wis. Stat. §51.42). This includes preparing short- and long-range plans to address substance use disorder treatment needs, maintaining oversight of the planning process, and maintaining an inventory of existing resources. Counties are required to report the National Outcomes Measures (NOMS) data through Wisconsin's Program Participation System (PPS), which populates the Treatment Episode Data Set (TEDS), and through the Substance Abuse Prevention Service Information System (SAP-SIS) through a contract with DHS. Direct grants awarded by DHS to private, non-profit, and county agencies are subject to performance management. Direct grant agencies are required to set performance objectives and report on progress on a semi-annual basis. DCTS contract administrators review these semi-annual reports and use the information to provide technical assistance and make contractual modifications as needed. Contract administrators also perform site visits to provider agencies to ensure programmatic and fiscal compliance and offer technical assistance as necessary.



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

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

Medication Assisted Treatment (MAT), including Medication for Opioid Use Disorder (MOUD), must be available to members who require it. Residential SUD treatment providers must provide MAT medication on site or enable access to the medication off-site and may not deny services to someone receiving MAT. Physicians and other qualified health professionals who perform psychiatric evaluation and management services, which may include psychotherapy performed with an evaluation and management service, may be reimbursed separately from the daily rate.

At this time, many residential providers have applied for and been approved as Medicaid providers, prior authorizations have been submitted and approved and individuals are accessing residential care through this new benefit.

### ***Prevention and Intervention Services***

#### ***Community Aids***

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

#### ***Brighter Futures Initiative (BFIP)***

DHS provides funding to the Wisconsin Department of Children and Families to support the Bright Futures Initiative (BFI). BFI promotes healthy families and youth; school success for youth; youth safety

in their families and communities; and successful navigation from adolescence to adulthood. The Initiative supports evidence-based prevention strategies and a positive youth development approach.

*Milwaukee Child Protection Services Substance Abuse Services*

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

*Alliance for Wisconsin Youth Regional Prevention Centers*

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

*Building Prevention Workforce capacity*

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

*Urban Youth Primary Substance Use Prevention*

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

*Injection Drug Use Prevention*

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

*Youth SU Prevention Services*

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

*Statewide Prevention Policies and Strategies*

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

*Program evaluation*

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

### ***Treatment Services***

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

#### ***Women's Treatment Services***

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

#### ***Urban Black and Hispanic Treatment***

Funds are distributed to Waukesha County and a community partner in Milwaukee County to reduce substance use in underserved communities by providing concentrated in-home care for African Americans and Hispanic individuals and families. Program activities include case management and coordination of services, in-home counseling, group education and counseling, and support for family members or other residential partners of person who misuse substances.

#### ***Injection Drug Use Treatment***

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

#### ***Coordinated Services Team (CST) Initiatives***

CST is designed to develop coordinated systems of care for children and adolescents with Severe Emotional Disorder (SED), and their families, who require support from multiple community-based agencies. Under the CST initiative a county or tribe is to establish a strength-based system of care that supports children and adolescents, along with their families, to address mental health, substance use, juvenile justice, and/or child welfare services. State General Purpose Revenue (GPR), MHBG, and

SUPTRS BG funds a small portion the services. Currently, 67 counties and 10 federally recognized tribal nations in Wisconsin participate in the CST Initiative. Additionally, Dane and Milwaukee counties offer a managed care model of this service.

#### *Integrated Peer Specialist Training and Certification*

Both SUPTRS BG and MHBG funds are used to support the development of certification curricula and the certification and training of family and other peer specialists. Wisconsin has implemented an integrated model for peer specialists, including training and certification to serve people with lived experiences in substance use, mental health, or both disorders.

#### *Parent Peer Specialist Training and Certification*

MHBG funds are used to support the development of certification curricula, certification, and training of Parent Peer Specialists. Parent Peer Specialists utilize their knowledge gained from parenting children and youth with mental health or substance use needs in combination with their training to guide and support other parents or those in a parenting role.

#### *Methamphetamine Treatment*

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

#### *Department of Corrections SU Treatment*

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

#### *Milwaukee Child Protection Services Substance Abuse Services*

DHS provides funding to the Wisconsin Department of Children and Families to provide substance use disorder services to Milwaukee County youth and family members.

#### *Youth Justice Screening and Diversion*

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

#### *STAR-QI Program*

STAR-QI is a quality improvement program designed to improve access to and retention in substance use disorder treatment. DHS works with treatment providers to modify and track changes in processes in order to increase admissions, reduce appointment no-shows and wait times, and increase successful treatment completion rates.

#### *Treatment Alternative Program (TAP)*

The TAP provides an alternative to incarceration for people with substance use disorders. Screening and assessment services are provided to develop an individualized treatment plan using a wraparound approach.

#### *Treatment Alternatives and Diversion (TAD)*

The TAD program provides alternatives to prosecution and/or incarceration for criminal offenders with substance use disorders.

#### *Voices for Recovery and Trauma-Informed Care*

DHS contracts with the University of Wisconsin-Madison to provide training and technical support to increase the number and reach of recovery coach organizations to offer peer support services by recovery coaches and/or certified peer support specialists, professional substance use disorder workers and providers on fighting stigma, recovery and trauma-informed care-based themes, and best practices.

#### *Problem-Solving Courts*

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

#### *Opioid Treatment Programs/Medication-Assisted Treatment*

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

#### *Statewide Training, Conferences and Technical Assistance*

DHS is currently partnering with UW-Milwaukee, School of Social Welfare, and the Center for Urban Population Health to conduct substance use disorder training needs assessments, and from those findings coordinate training, conferences, and technical assistance activities focusing on a wide array of best practice programming strategies and models.

#### *Emerging Leaders Workforce Development Program*

DCTS offers this free workforce development program, which provides training and mentorship to Wisconsin-based behavioral health professionals in the African American; Hispanic/Latinx; Asian; Middle Eastern/Northern African; Native American/Alaskan Native; and minority LGBTQ2S+ communities.

#### *Helpline and Hotline Assistance*

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

### **Behavioral Health Services**

A continuum of services has been developed to meet the needs of persons with mental illness and substance use disorders in Wisconsin. Originally a large divide existed between mental health and substance use disorder treatment programs. With the evolving service system, various programs are not only expected to treat persons with co-occurring disorders but are progressively more skilled at doing so. The DCTS continues to work to better integrate mental health and substance use services and integration remains a strategic focus.

One of the primary services utilized in Wisconsin is the outpatient mental health program. This program is designed as a Medicaid reimbursed clinic where a person can receive services from a psychotherapist, psychiatrist, nurse prescriber, or nurse practitioner.

#### *Comprehensive Community Services (CCS)*

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

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

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

#### *Community Support Programs (CSP)*

CSPs provide coordinated care and treatment through a single agency. This program provides a range of treatment, rehabilitation, and support services in the community through an identified treatment program and staff ensuring ongoing therapeutic involvement and individualized treatment for persons with severe and persistent mental illnesses. Additionally, CSPs work collaboratively with other community partners and support consumers in utilizing outside resources such as housing programs, Medicaid, Social Security, and self-help groups. The program uses the Assertive Community Treatment (ACT) model as a foundation. The CSP has multi-disciplinary mental health staff organized as an accountable, mobile team. These teams function interchangeably to provide treatment, education about mental illness, rehabilitation, crisis, and supportive services to persons who have a serious and persistent mental illness that affects both their ability to live independently in the community and to function in major life roles. In Wisconsin there are currently 68 certified CSPs providing services to 65 counties. Five counties utilize a shared CSP model: Human Services Center (Forest, Oneida, and Vilas); North Central Health Care (Marathon, Lincoln, and Langlade); WRIC (La Crosse, Monroe, and Jackson); WRRWC (Chippewa, Pepin, and Buffalo), and Unified Services (Grant and Iowa). Another five of the larger counties have more than one CSP within their county: Brown (2); Dane (4); Milwaukee (7); Rock (2); and Winnebago (2). Seven counties do not have a certified CSP.

#### *Community Recovery Services (CRS)*

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

Wisconsin's CRS benefit expects recovery-oriented, outcome-based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. Three services are provided through the CRS initiative: 1) Community Living Supportive Services (CLSS) covering services necessary to allow individuals to live with maximum independence in community integrated housing including skill training, cuing, and/or supervision as identified by the person-centered assessment. 2) Supported Employment Services includes services necessary to assist

individuals to obtain and maintain competitive employment using the Individual Placement and Support (IPS) model recognized by SAMHSA as an evidence-based practice. 3) Peer Support Services utilizing individuals trained and certified as Peer Specialists to serve as advocates, and to provide information and peer support for consumers in outpatient and other community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Currently 17 counties in Wisconsin are actively providing CRS.

## **Services for Children, Youth, and Young Adults**

### *Coordinated Service Team (CST) Initiatives*

There are growing county and tribal initiatives in Wisconsin to assist children and youth with behavioral health conditions. CST is designed to develop coordinated systems of care for children and adolescents with Severe Emotional Disorder (SED), and their families, who require support from multiple community-based agencies. Under the CST plan a county or tribe is to establish a strength-based system of care that supports children and adolescents along with their families, mental health, juvenile justice, and/or child welfare services. Through these efforts an overall systems change is possible, which can establish a collaborative system of care which provides counties and tribes the capacity to meet the needs of youth and their families. The 2009 Wisconsin Act 334 allowed for the expansion of CST services to youth who were not diagnosed with an SED, but who were involved in more than one system of care and had a risk of going into an out-of-home placement. The 2013-2015 state budget provided funding to expand CST Initiatives statewide. Currently, 67 counties and 10 federally recognized tribal nations in Wisconsin participate in the CST Initiative. Two counties, Dane, and Milwaukee, provide a managed care model of this service.

### *Healthy Transitions Initiative*

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

### *Program for Assertive Community Treatment*

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



### *Children's Long-Term Support Waivers*

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

### *Coordinated Specialty Care (CSC)*

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

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

Wisconsin plans to continue funding CSC model programs in FFY 2024 and FFY 2025. It is anticipated that all current providers will continue to receive funding in FFY 2024, and new sites will be identified through a competitive procurement process in FFY 2025.

### **Crisis Services**

In Wisconsin, Crisis Intervention, administered under DHS 34, subchapter III administrative rule, is available through three modalities, at minimum: 24/7 telephone services; 8 hours per day, 5-day per week walk-in service; and 8-hour per day, 7-day per week mobile services, including mobile crisis outreach. Programs certified under subchapter III are eligible to claim reimbursement for service provision through Wisconsin Medicaid through an established fee-for-service rate structure and private insurers as well (Wisconsin administrative rule requires Crisis Intervention Services to be covered under Casualty Insurance: INS 3.37). Most of Wisconsin's 72 counties are under an umbrella of DHS 34, subchapter III programs, either as a certified entity themselves or by contracting with a private agency or adjacent county. Crisis stabilization services are an optional service certified programs may provide and receive reimbursement for. In Wisconsin there are approximately 20 crisis stabilization facilities operated by counties throughout Wisconsin, five regionalized crisis stabilization facilities that are supported through DHS grant funds, and three youth crisis stabilization facilities supported through DHS grant funds.

Eligibility for subchapter III crisis service is broadly defined as "a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual." Wisconsin Crisis programs are also capable of preparing and implementing a "Crisis Plan" for "an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs." Thus, Crisis programs provide both emergency responses to an emergent situation as well as anticipatory crisis planning.

Programs are required to provide linkage, coordination, and follow-up services as well. Consequently, these programs are making referrals and connecting individuals and their families to mainstream resources to stabilize a crisis and to prevent the emergence of another. Crisis services have enabled diversion from a great many unnecessary psychiatric hospitalizations. In Wisconsin, for an individual to be involuntarily hospitalized under an emergency detention, the county department of community programs must provide a "crisis assessment" and approve the transfer to a treatment facility. In almost all cases, that authority is with the Crisis Intervention program, delegated to a mental health professional, Wisconsin Stats. Chapter 51.15 (2) (c). This requirement affords an opportunity to evaluate the necessity for a hospitalization or alternatively to employ a more trauma informed least restrictive alternative such as a community safety plan or a crisis stabilization option, either in-vivo or in a residential setting. Stabilization in place or use of residential stabilization resources are optional services for Subchapter III certified programs. Many counties have residential stabilization facilities for adults, either one to two bed county-licensed Adult Family Homes (AFHs) or larger-state three to four bed AFHs or five to 16 bed state-licensed Community-Based Residential Facilities (CBRFs). Regionalized crisis stabilization facilities (RCSF) are currently in operation or development in all five regions of the state however, based on geography may not serve all counties within the region. These RCSFs are partially

funded through a DHS grant. Additionally, there are three operating, certified, youth crisis stabilization facilities in the state which provide short term, crisis stabilization services for youth.

### ***Suicide and Crisis Lifeline Network***

Sixty-five of Wisconsin's 72 counties have Medicaid reimbursable, certified crisis programs which requires them to operate crisis call lines for least 8 hours a day, 7 days a week. Starting January 1<sup>st</sup>, 2024, county crisis programs can enroll with Medicaid to receive an enhanced benefit which would allow billing for a team of up to three mobile crisis providers, one requirement to receive an enhanced benefit is to have mobile crisis teaming available 24 hours a day, 7 days a week. While many of these lines aren't defined "centers" they do need to be able 24 hours a day, 7 days a week to provide callers with information, support, counseling, intervention, emergency service coordination, and referrals. Wisconsin has one primary 988 Suicide and Crisis Lifeline center that answers all calls, chats and texts, the 988 Wisconsin Lifeline and one backup center. Both are operated by Family Services of Northeast Wisconsin. In summer of 2023 through a partnership with Mental Health America of Wisconsin a new peer support warmline was developed. The warmline is a non-emergency service built for people experiencing mental health and substance use concerns staffed by people who have navigated their own mental health and substance use concerns. The operators are trained on how to use their personal experiences to guide and support others.

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

### **Services for Older Adults**

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

Another program in Wisconsin associated with Family Care is the Include, Respect, I Self-Direct (IRIS) program. IRIS is a self-directed home and community-based waiver program with a monthly allotment

where the participant can use public funds and natural supports to craft their own support and service network. These programs are connected to Aging and Disability Resource Centers (ADRC), which serve as the entry point for a person who may need supportive community services. Data show that over half of those enrolled in Family Care also carry a mental health diagnosis.

### **Services for Priority Populations**

#### *Pregnant Women and Women with Dependent Children*

As noted by the Wisconsin Maternal Mortality Review team, women with substance use issues have higher rates of unplanned pregnancies, and many women do not have the necessary support, treatment, and resources to address their substance use before, during, and after pregnancy. Accessible, gender-responsive substance use treatment services are needed for women, including pregnant women and women with dependent children.

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

DCTS further increases and enhances the number and quality of substance use disorder prevention, intervention, and treatment services for pregnant women and women with dependent children through training and technical assistance services to counties, community-based providers, and tribes. Training and technical assistance supports providers in developing and implementing evidence-based substance use programming and services for pregnant women and women with dependent children.

#### *Persons at Risk for Tuberculosis*

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

compliance with TB screening and referral requirements. Additionally, counties are required to report on their adherence to TB screening and referral requirements as part of annual reporting.

## **Services for Special Populations**

### *Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) Populations*

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

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

### *Rural Populations*

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

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

The use of Telehealth in Wisconsin since 2007 has been increasing to help address the need for an array of MH/SA services. Psychiatry services are lacking in many rural areas. Recent efforts to increase Telehealth services in Wisconsin include a state-funded Child Psychiatry Consultation Program to provide support to physicians in two programs, one rural and one urban. A child psychiatrist is available via phone to consult with a pediatrician or other primary care physician to support them in providing mental health treatment in the primary care office. Telehealth has become increasingly a part of the Wisconsin behavioral health treatment system with the COVID pandemic. A rule is currently underway, led by the Division of Medicaid Services, to allow for continued use of telehealth as a treatment modality.

### *Services to Individuals Who are Homeless*

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

Through the Projects to Assist in the Transition from Homelessness (PATH), and programs such as HOME Tenant-Based Rental Assistance (TBRA), HUD-funded Emergency Solutions Grant (HEARTH 24 CFR part 91 and 576) and state-funded shelter, transitional living, and homelessness prevention grants— Wisconsin provides a range of services to those who are homeless or are at risk of homelessness. Additionally, Wisconsin's initiatives in SSI/SSDI Outreach, Access, and Recovery (SOAR) have assisted many homeless and disenfranchised individuals obtain urgently needed disability and insurance benefits with which to support a life off the street. Having related medical insurance greatly improves access to medical and behavioral health treatment.

The central objective of PATH is outreach to locate and engage people experiencing homelessness who have a mental illness or co-occurring disorder and to facilitate enrollment in PATH services. The PATH program transitioned from the previous administering agency, the Wisconsin Department of Administration, to the DHS, DCTS at the start of State Fiscal Year (SFY) 18. Additionally, the United States Department of Housing and Urban Development (HUD) supported housing initiatives exist in both urban and rural communities across the state, funding transitional and permanent housing programs. HUD funds several levels of supportive housing including Safe Havens, Transitional Housing, and Shelter-Plus-Care. Although no new Safe Haven projects are being funded through HUD, existing programs provide a soft entry refuge for people who are unable or unwilling to immediately engage in supportive services.

### *Racial and Ethnic Minorities*

In 2021, the Health Equity, Diversity, and Inclusion (HEDI) Council launched. HEDI is a group of equity-driven members who are working to provide analysis, insights, and recommendations to DHS on internal and external policies, programs, and projects related to diversity, equity, inclusion, and affirmative action. HEDI is made up of members from each division and office at DHS who can provide expertise and recommendations to help inform the work.

A primary focus area of the BPTR has been the implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards. The BPTR previously developed and implemented a training plan for CLAS education and training within the DDCTS, DHS, and external partners and providers. A The BPTR has begun including language in contracts regarding CLAS Standards to encourage comprehensive implementation of these standards.

The BPTR developed a comprehensive Diversity, Equity, and Inclusion Plan in 2021 with the mission to dismantle systemic inequities and transform behavioral health practice and policy through innovation and transparent collaboration. The plan centers around five key areas, including: hiring, retention, and advance practice for diverse populations; data collection for driving DEI decisions; internal and external partner workforce development; funding and contracting practices; and CLAS standards. On a recurring basis the DCTS holds a very successful Leadership Institute that DHS first provided in 2013. The Leadership Institute is a comprehensive program that enhances the leadership and technical competencies of emerging behavioral health leaders from minority communities. The program combines targeted training, mentoring by allied professionals, and a capstone project for emerging leaders. The program is designed to give emerging leaders of the state's four underserved communities; African American, Hispanic, Hmong, and Native American the opportunity to enhance their leadership skills and participate in an interactive learning community. The institute's goal is to increase quality of staff and staff retention in the underserved communities. A new round of the institute will begin in January 2022.

#### *Tribal Nations*

DHS Area Administrators and DCTS representatives attend a joint consultation with the Tribal State Office with tribal councils twice per year. On a quarterly basis, DHS staff attends the Family Service program directors' meeting from the eleven tribes to learn of local activities, identify unmet needs, and provide technical assistance as needed. In addition, DHS staff members also attend monthly meetings with the Tribal State Collaborative for Positive Change (TSCPC) that includes mental health and substance use coordinators to listen, identify unmet needs, and provide or arrange for technical assistance for the tribal staff. This includes both prevention and intervention needs.

Two CCS State Coordinators work with tribes to support current CCS programs and to develop interest in providing CCS with tribes without the program. The coordinators attend one-on-one meetings with staff and meetings with tribal leaders to educate tribes on what CCS is and how tribes can benefit from providing the program. If a tribe is interested, the coordinators work directly with tribal leadership to understand the program requirements and develop their program plan. Once the tribal program is state certified, coordinators continue to provide training and technical assistance to assist the tribe to operationalize their program to meet state and Medicaid guidelines while maintaining their tribal focus. It is imperative for the coordinators to understand the unique needs of each tribe and assist the tribe to design a program that will meet those needs.

DHS staff continue to discuss and brainstorm possible solutions in addressing the workforce shortage issue with tribal staff and agencies, including distribution of tribal job announcements, identification of potential job applicants, and forwarding potential applicants to tribal staff.

DHS conducts a Substance Abuse Prevention Training (SAPT) event specifically for tribal staff in the spring each year. Of the two trainers, one is from the tribal community. Attendees have said they enjoyed the training and found it valuable. Wisconsin also supports tribal substance use disorder

prevention services for Wisconsin's 11 federally recognized Native American tribes through the Family Services Program.

Staff also attend quarterly Tribal Office meetings to learn of statewide trends in tribal communities and to coordinate, and collaborate with other departments and offices within DHS, including the Office of Tribal Affairs, in improving services for tribal communities.

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## Planning Steps

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

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System (URS)**, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*<sup>1</sup> in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

#### Footnotes:

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

The Division of Care and Treatment Services (DCTS) analyzes existing data as part of an ongoing process to inform future policy and funding decisions.

The data and analysis featured in this section of the application are from three broad categories. Data sets covering mental health and substance use services are highlighted in each of these categories.

- **Prevalence of Needs and Service Utilization:** The prevalence of disorders, conditions, and associated problems for the entire population is examined. The prevalence in subpopulations is examined when available. The service utilization in the public behavioral health system (county-authorized) is also presented.
- **Access to Services:** Data on access to services is examined to determine which and how many individuals receive services. Barriers to access are explored.
- **Service Workforce and Capacity:** Available information on the size of mental health and substance use services workforce is examined including the number of providers of these services and the geographic dispersion of the workforce across the state.

The most recent data consistently available at the time of this application was utilized, and is noted by data source below.

### Prevalence of Needs and Service Utilization

#### Mental health

##### Most recent statewide prevalence rates

Two types of mental health prevalence rates are described. If both symptoms and functional impairment exist, the individual is estimated to have a serious mental illness. The term for children in this category is severe emotional disorder. A second group of individuals with more mild mental health conditions experience symptoms but are still able to function for the most part in their daily life. Together, these two groups are sometimes called individuals with any mental illness. The adult any mental illness and serious mental illness national rates for the most recent year available (2021) and the year of the previous Wisconsin needs assessment (2019) are compared in Table 1 to examine the current rates and any changes in the past two years.

**Table 1: Adult Mental Health Prevalence – 2019 and 2021 National Rates**

<b>Demographic Characteristic</b>	<b>Any Mental Illness (2019)</b>	<b>Serious Mental Illness (2019)</b>	<b>Any Mental Illness (2021)</b>	<b>Serious Mental Illness (2021)</b>
<b>TOTAL</b>	20.6	5.2	22.8	5.5
<b>AGE GROUP</b>				
18-25	29.4	8.6	33.7	11.4
26 or Older	19.2	4.7	21.1	4.7
26-49	25	6.8	28.1	7.1
50 or Older	14.1	2.9	15.0	2.5
<b>GENDER</b>				
Male	16.3	3.9	18.1	4.0
Female	24.5	6.5	27.2	7.0
<b>HISPANIC ORIGIN AND RACE</b>				
Not Hispanic or Latino	21.1	5.3	23.2	5.6
White	22.2	5.7	23.9	6.1
Black or African American	17.3	4	21.4	4.3
American Indian and Alaska Native (AIAN)	18.7	6.7	26.6	9.3

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Native Hawaiian and Other Pacific Islander (NHOPI)	16.6	2.6	18.1	6.3
Asian	14.4	3.1	16.4	2.8
Two or More Races	31.7	9.3	34.9	8.2
Hispanic or Latino	18	4.9	20.7	5.1
<b>EMPLOYMENT STATUS</b>				
Full-Time	19.2	4.6	21.6	4.9
Part-Time	25	6.8	29.5	7.9
Unemployed	27.7	8.4	32.2	9.0
Other <sup>1</sup>	20.1	5.2	20.7	5.1

\* = low precision; -- = not available; da = does not apply; nr = not reported due to measurement issues.  
 NOTE: Estimates from years prior to 2021 are not shown because of methodological changes in 2021.  
 See the *2021 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Mental Illness aligns with DSM-IV criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Estimates of serious mental illness (SMI) are a subset of estimates of any mental illness (AMI) because SMI is limited to people with AMI that resulted in serious functional impairment. These mental illness estimates are based on a predictive model and are not direct measures of diagnostic status.

1 Other Employment includes students, people keeping house or caring for children full time, retired or disabled people, or other people not in the labor force.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

- The overall national rates of any mental illness and serious mental illness have increased slightly from 2019 to 2021.
- People aged 18-25 have higher rates of AMI and SMI compared to other age groups.

- Multi-racial and American Indian and Alaska Native (AIAN) individuals have relatively higher rates of mental health needs.

**Table 2: Mental Health Prevalence Indicators for Wisconsin - 2021**

Wisconsin	12-17 years	18-25 years	26+ years	18+ years – All Adults
	Percent			
Major Depressive Episode	19.3	18.49	7.42	8.9
Serious Mental Illness	--	10.27	5.33	6.00
Any Mental Illness	--	6.69	21.2	23.76

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

- In Table 2, Wisconsin adults rank higher than several other states on the prevalence of serious mental illness.
- Wisconsin adults rank higher than several other states on the prevalence of any mental illness.

Children and youth in Wisconsin, and attentionally, continue to experience high rates of mental health challenges. Estimates for the number of children with any mental illness and children with SED are from the National Institute of Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders study (21 percent and 11 percent). According to the 2022 CDC Youth Risk Behavior Survey: Wisconsin High School Survey, “22% of Wisconsin high schoolers reported self-harm behaviors, 25% of female-identified students seriously considered attempting suicide, 34% of students felt sad or hopeless nearly every day, 48% of Wisconsin LGBTQ+ youth reported seriously considering suicide, and 52% of students reported experiencing extreme anxiety” (CDC Youth Risk Behavior Study, 2022). According to the 2020-2021 National Survey of Children’s Health 51.5% of children ages 3-17 in Wisconsin with a mental/behavioral health condition received treatment of counseling, slightly lower than the national average of 51.6%. According to the national High School Youth Risk Behavior Survey (2021) 29.3 percent of highschoolers reported that their mental health was most of the time, or always, not good. Nationally, 36.9% of highschoolers reported that their mental health was most of the time or always not good during the COVID-19 pandemic.

### Specific population prevalence rates

Table 4 highlights specific population groups known to have high rates of mental health needs. These groups and their rankings have not changed much in the past decade.

**Table 3: Population Groups with Highest Prevalence Rates - 2021**

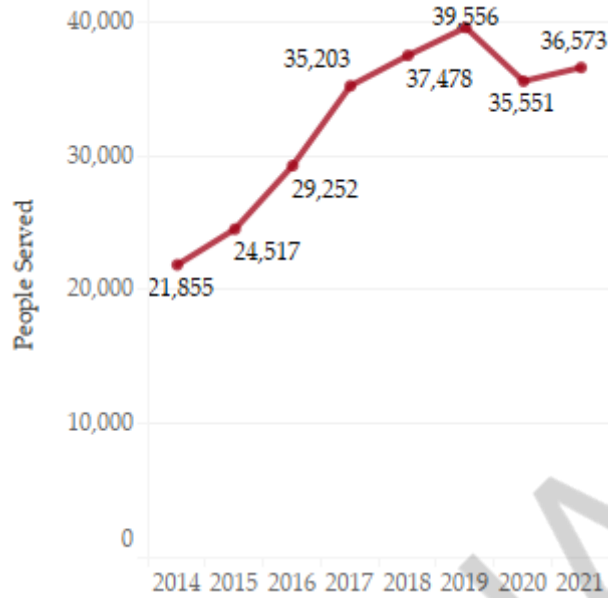
<b>Population Group</b>	<b>Any Mental Illness Prevalence Rate (% of population)</b>
Females	27.2
Veterans	16.1
Lesbian, Gay, or Bisexual 18+ (LGB)	50.9
Two or More Races	34.9
American Indian Alaskan Native	24.6
Non-Hispanic Black	21.4
Asian	16.4

Sources: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

### **Mental Health Services Utilization**

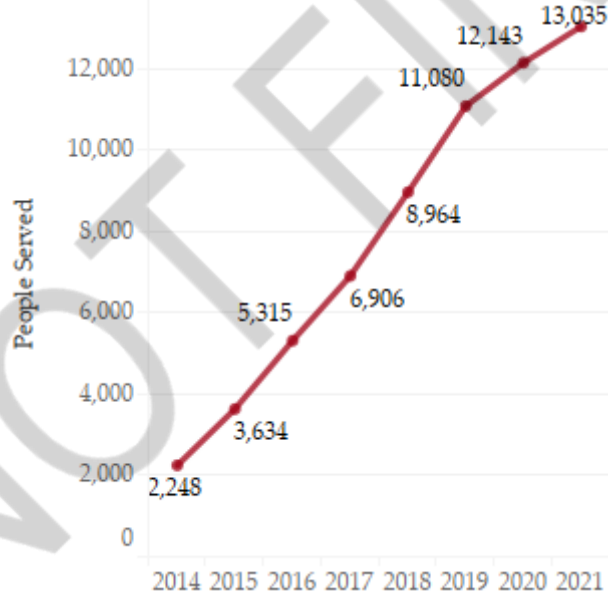
According to data collected via the DHS Program Participation System (PPS). It is important to note that PPS data largely captures county-authorized services and is a more limited view of service provision in Wisconsin. The five most used services in Wisconsin in 2021 were Crisis (36,573), Outpatient Counseling (16,302), Medication Management (13,230), Comprehensive Community Services (CCS) (13,035), and Care Management (10,872). Crisis Service utilization (Figure 1) has been on an upward trend since 2014, with some decline in 2020. During this same period Wisconsin has seen an increase in the utilization of CCS. While Wisconsin has seen an increase in the utilization of Crisis Services and CCS, during the same period there has been a steady decline in the utilization of Outpatient Counseling Services in the public behavioral health system (Figure 3).

**Figure 1: Crisis Service Utilization**



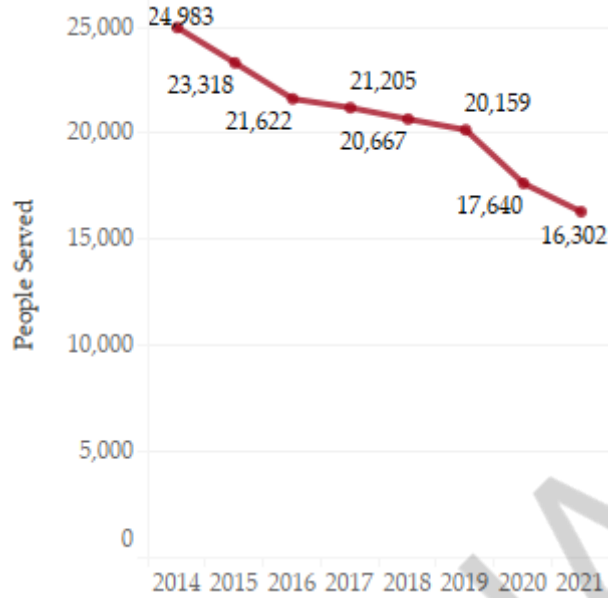
Source: DHS Mental Health County Services Dashboard

**Figure 2: Comprehensive Community Services Utilization**



Source: DHS Mental Health County Services Dashboard

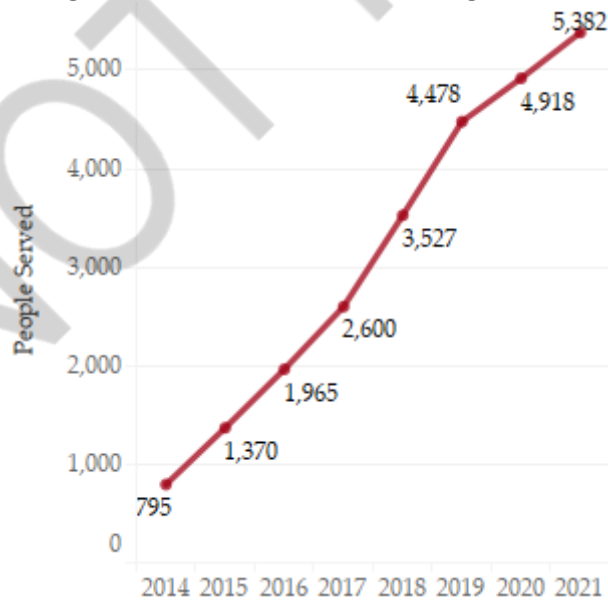
**Figure 3: Outpatient Counseling Service Utilization**



Source: DHS Mental Health County Services Dashboard

Utilizing the same data source, the five most used services for children aged 0-17 in Wisconsin in 2021 were Crisis (7,135), CCS (5,382), Outpatient Counseling (3,198), Case Management (2,172), and Intake and Assessment (1,259). Since 2014, there has been an increase in the utilization among children aged 0-17 for Crisis Services and CCS (Figure 4), and a decline in Outpatient counseling, mirroring those trends observed among the general population in Wisconsin.

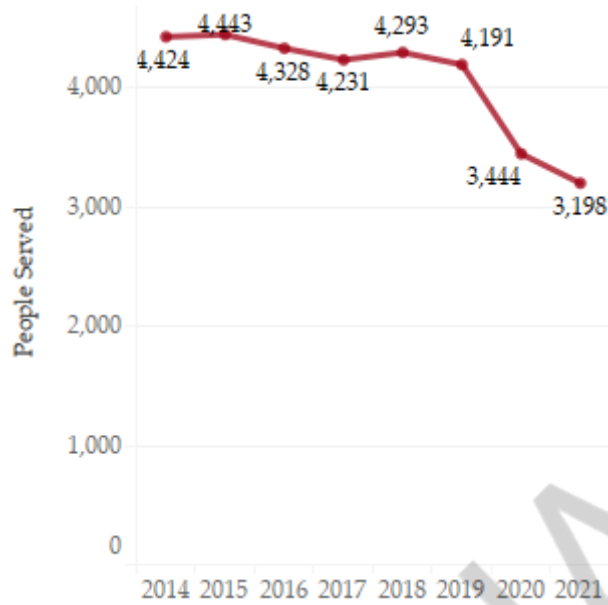
**Figure 4: CCS Utilization Children aged 0-17**



Source: DHS Mental Health County Services Dashboard

**Figure 5: Outpatient Counseling Utilization Children aged 0-17**



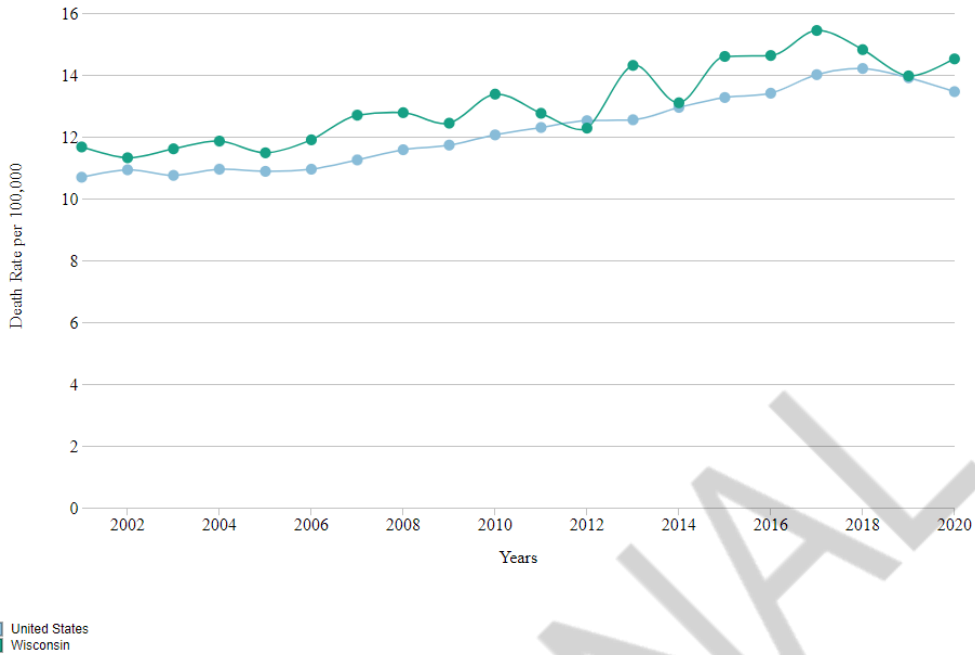


Source: DHS Mental Health County Services Dashboard

**Priority highlight: Suicide**

Wisconsin has had a suicide rate slightly higher than the national average over the last 18 years and calendar year 2020 was no different as illustrated in Figure 6. Wisconsin’s suicide rate has been higher than the national rate every year except for once since 2005 and both rates have experienced a generally increasing trend over that period. Wisconsin’s rate in 2020 (14.5) was higher than it’s been since 2017 (15.5).

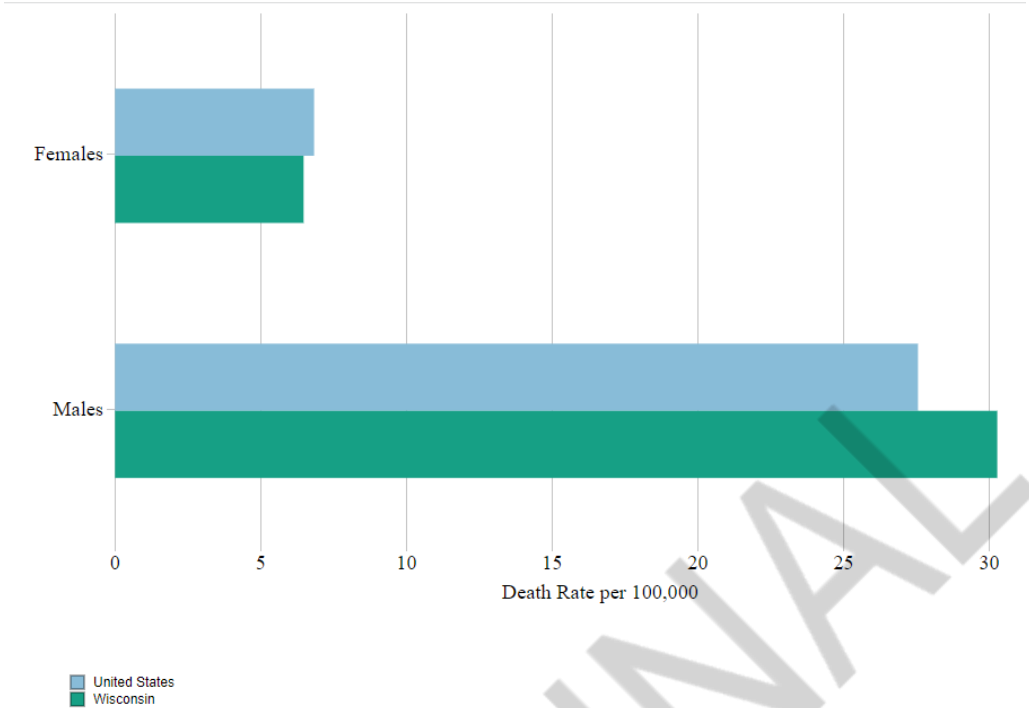
**Figure 6: Suicide Rates 2002-2020 (Age-Adjusted)**



Source: Center for Disease Control’s WISQARS Injury Mortality Reports for Suicides.

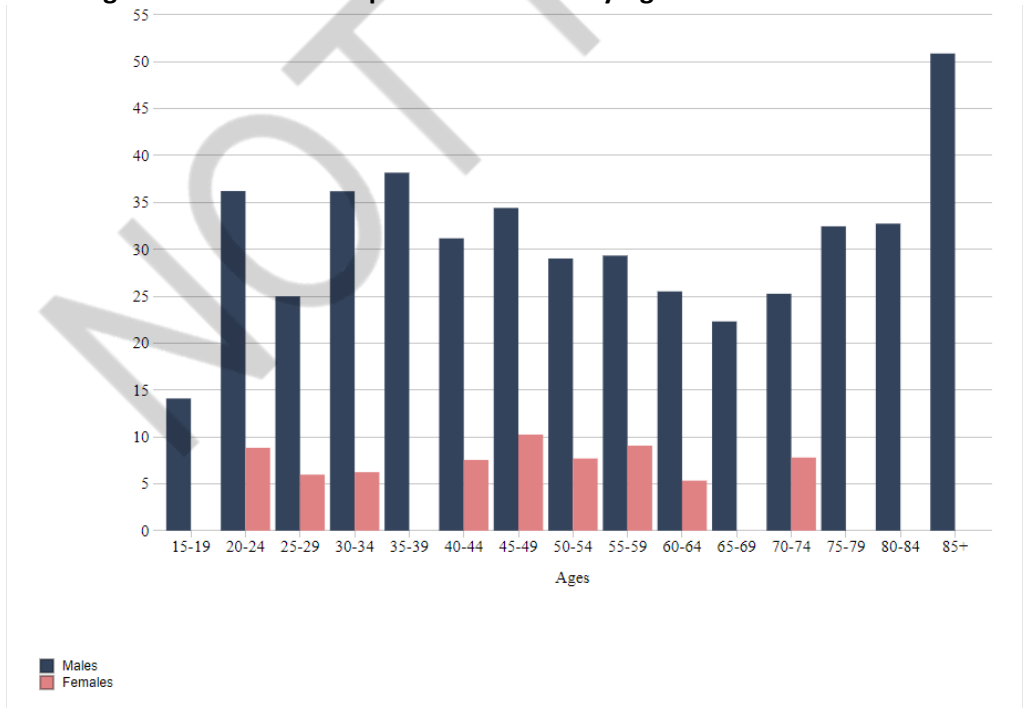
Additional disparities in Wisconsin’s suicide rate exist based on age and sex. Although the suicide rate is higher in Wisconsin than the United States in general, this is especially true for the male population (30.27 for WI vs 27.6 for the US). Women in Wisconsin actually have a rate slightly lower than the national average (6.5 vs. 6.8) (Figure 7). The rate of suicide amongst males is significantly higher than amongst females in Wisconsin and nationally for every age group (Figure 8). The suicide rate peaks at ages 85+ for males in Wisconsin and at ages 45-49 for females.

**Figure 7: Suicide Rates by Age Groups and Sex, 2020**



Source: Center for Disease Control’s WISQARS Injury Mortality Reports for Suicides; multiple years are combined to provide more reliable rates within the narrow age groups.

Figure 8: Self-Harm Hospitalization Rates by Age and Sex for 2020-2021



Source: Wisconsin Hospital Association hospital discharge data.

## Substance Use

### Most recent statewide prevalence rates

A person having a substance use disorder means that they meet the screening criteria of a negative pattern of alcohol or other mood-altering drug misuse or addiction, resulting in significant health, social, psychological, or vocational impairment or distress and where intervention or treatment is advised. Table 5 displays the rate of substance use disorder among Wisconsin residents compared with the national rate. Wisconsin's rate of substance use disorder exceeds the national rate for both adults ages 18 and older and youths ages 12-17.

**Table 5: Wisconsin Substance Use Disorder in the Past Year, by Age, 2018-2019**

Measure	2017-2018		2018-2019	
	Wisconsin	U.S.	Wisconsin	U.S.
Substance Use Disorder, 18+	8.7%	7.7%	8.0%	7.7%
Substance Use Disorder, 12-17	4.1%	4.1%	4.3%	4.1%

Source: 2021 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

Table 6 below portrays rates of substance use among different substances compared to the U.S. average. In particular, the rate of past month alcohol use in Wisconsin is higher than the national average.

**Table 6: Substance Use, by Substance, Age 12+, 2018-2019**

Measure	2017-2018		2018-2019	
	Wisconsin	U.S.	Wisconsin	U.S.
Past month alcohol use	59.6%	51.4%	59.9%	50.9%
Past year marijuana use	13.6%	15.5%	14.6%	16.7%**
Past year cocaine use	2.3%	2.1%	2.0%**	2.0%**
Past year heroin use	0.4%	0.3%	0.3%	0.3%
Past year pain reliever misuse	4.2%	3.9%	3.9%	3.6%**

Source: 2021 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

\*Past year opioid misuse measure is not released yet for combined 2019-2020 National Survey on Drug Use and Health survey.

\*\*Statistically significant difference from value on previous National Survey on Drug Use and Health survey year (.05 level).

### Population group prevalence rates

Estimates from the National Survey on Drug Use and Health suggest that rates of substance use disorder vary across different population groups and some groups may be of particular interest also due to their projected prominence in the U.S. population. Table 7 shows the prevalence rates of individuals having a substance use disorder for selected target populations.

**Table 7: Population Groups with Highest Prevalence**

<b>Population Group</b>	<b>Substance Use Disorder Prevalence Rate (% of population)</b>
Corrections (Adults)	56.0
Homeless	34.7
Corrections (Juveniles)	35.1
County Jails	32.0
Trauma	21.5
Mental Illness	18.3
Pregnant	16.6
LGBT	16.4
Native American	12.8
Deaf or Hard of Hearing	12.0

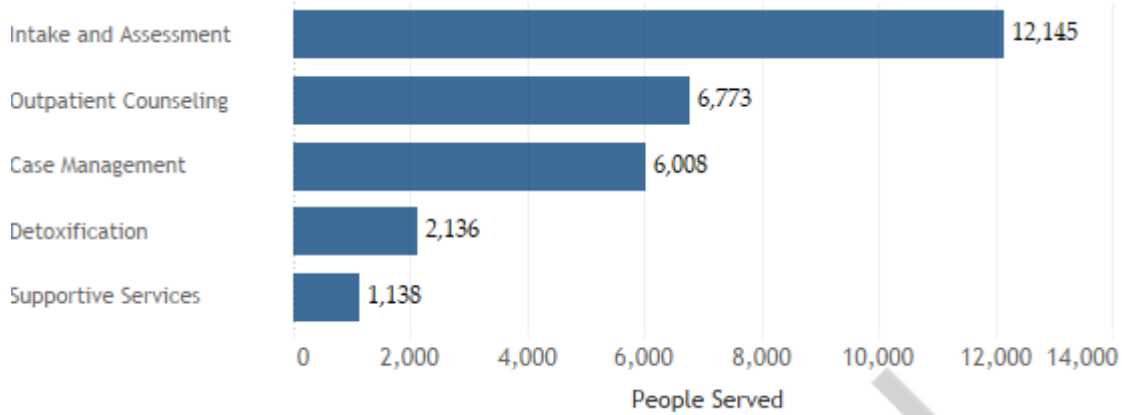
Sources: See Appendix.

### **Substance Use Service Utilization**

According to data collected via the DHS PPS the five most used substance use services in Wisconsin in 2021 (Figure 9) were Intake and Assessment (12,145), Outpatient Counseling (6,773), Case Management (6,008), Detoxification (2,136), and Supportive Services (1,138). Alcohol was the most common substance people were receiving services to address (Figure 10). Overall since 2019 there has been a decline in the number of people receiving county authorized substance use services. In 2019 30,198 people were served in this system according to PPS, and that number had declined to 23,016 in 2020, and to 21,836 in 2021. This decline in service may have its roots in the impacts of the COVID-19 pandemic which impacted the ability of providers to provide services, and also potentially people's ability or willingness to seek out treatment due to the risks of COVID-19. This trend will be important to monitor as other data indicates the need for substance use treatment is increasing rather than declining, indicating a treatment gap.

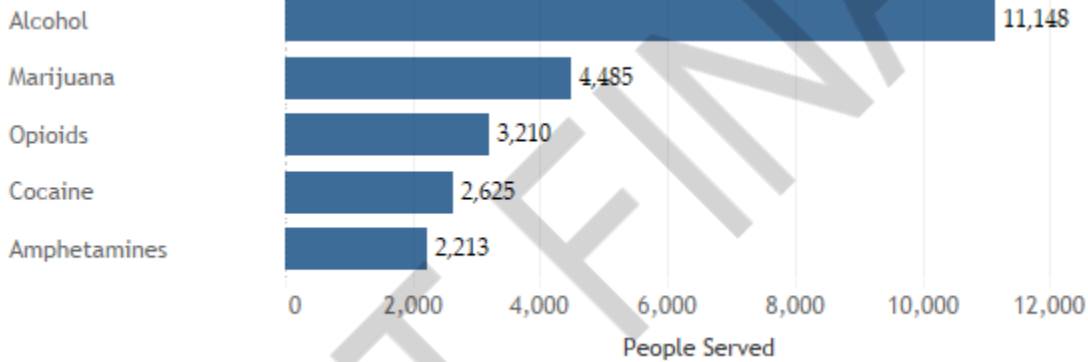
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**Figure 9: Top County Substance Use Services Provided in 2021**



Source: DHS Substance Use County Services Dashboard

**Figure 10: Number of people served in County Services by Substance in 2021**



Source: DHS Substance Use County Services Dashboard

**Priority highlight: Opioids**

Since the early 2000s, Wisconsin has been experiencing a surge in opioid misuse and its related harmful consequences. Wisconsin’s past year heroin use rate and past year pain reliever misuse Among Wisconsin’s 72 counties, the number of counties with any opioid-related deaths increased from 36 counties to 60 counties between 2004 and 2017. The prevalence of illicit and nonmedical use of opioids can be estimated from the National Survey on Drug Use and Health, Wisconsin sample data. Averaged across 2015 and 2016, 3.3 percent of Wisconsin individuals age 12 and older misused opioid-based medications in the past year, slightly less than the national average.

**Table 8: Opioid Use in the Past Year, Age 12+, 2018-2019**

Measure	Wisconsin	U.S.
Past Year Heroin Use	.34%	.28%
Past Year pain reliever misuse	3.87%	3.58%

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

**Table 9: Opioid Use in the Past Year, Age 12+, 2021, (Rates per 1,000 Population)**

Measure	Wisconsin	U.S.
Past Year Opioid Use Disorder	2.09	1.99
Needing but not Receiving Treatment for Illicit Drug Use in the Past Year	6.80	6.78

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

Many individuals with an addiction to opioids begin their opioid use with a prescription for pain medication such as codeine, oxycodone, or hydrocodone. In recent years, the number of individuals in Wisconsin who obtain an opioid prescription has decreased, as has the number of opioid prescriptions filled each year (Table 10). Prescriptions have seen a downward trend every year since 2018, with the exception of an uptick in 2021 after a large decrease in 2020.

**Table 10: Wisconsin Opioid Prescriptions**

Prescription Indicator	2018	2019	2020	2021	2022
Individuals Obtaining an Opioid Prescription	910,041	851,009	773,059	794,819	763,393
Prescriptions Dispensed	3,569,147	3,319,308	3,098,088	2,998,274	2,835,996
Average Prescriptions Filled Per Person Obtaining an Opioid Prescription	3.92	3.90	4.01	3.77	3.71

Source: Prescription Drug Monitoring Program, Wisconsin Department of Safety and Professional Services.

Table 11 demonstrates disparities across race and ethnicity in opioid-related deaths in Wisconsin. From 2016-2021, American Indians had the highest rate of opioid-related deaths followed by Black individuals. Not only do these historically underserved populations have the highest rate of opioid-related deaths, their rate of death has also been increasing faster than other populations.

**Table 11: Drug Overdose Deaths Involving Any Opioid by Race or Ethnicity, Wisconsin, 2016-2018 and 2019-2021 Combined (Rates per 100,000 Population)**

Race or Ethnicity	2016-2018 Number	2016-2018 Rate	2019-2021 Number	2019-2021 Rate
Black	272	21.5	560	42.8
American Indian	63	28.0	109	46.4
White	2281	14.9	2882	18.8
Hispanic	141	12.0	232	18.3
Asian	4	.9	23	4.0

Source: Wisconsin Death Certificates, DHS.

**Table 12: Drug Overdose Deaths Involving Any Opioid by Age Group, Wisconsin, 2016-2018 and 2019-2021 Combined (Rates per 100,000 Population)**

Age Group	2016-2018 Number	2016-2018 Rate	2019-2021 Number	2019-2021 Rate
1-17	17	0.5	15	0.4
18-44	1634	27.6	2178	36.2
45-64	873	18.6	1237	25.8
65+	96	3.4	143	5.4

**Access to Services**

The number of participants served is sometimes referred to as treated prevalence. Treated prevalence is defined as the percentage of individuals with needs who actually received services. The untreated prevalence describes the treatment gap between the population in need and the population that is served.

Individuals served in both public and private systems are included in analyses below. Figure 6 illustrates all major providers and insurers of mental health services in Wisconsin and provides a general portrayal of how services may overlap or remain distinct. The public system is defined as both services provided by public agencies and services paid for with public funds. The public providers are primarily the county-based service system and the two state mental health institutes. The state correctional institutions provide services to a small number of individuals which could also be categorized as a component of the public service system. The largest single funder of public services is Medicaid for both mental health and substance use, although private providers may also use Medicaid. The largest provider of mental health services overall is the commercial insurance sector. Commercial insurance plays a major role in the substance use system as well, but Medicaid funds are used more than any other funding source for substance use services. Two smaller groups for which no data is available include individuals who use employer-funded insurance plans or pay directly.

Table 12 describes how many adult and youth service participants received mental health services from different service sectors and funding sources in 2022 (note some data points utilize 2017 data as that is the most current data available at the time of writing). While many service participants (63,835) access mental health services through the public county system using a variety of potential funding sources, many more access services using a Medicaid fee-for-service (156,127) or Medicaid managed care (145,524) arrangement. While the different programs and providers listed in the table represent different data sets analyzed for this report, many participants use more than one of these programs and providers to access their mental health services.

The commercial insurance sector serves the most participants overall which included 274,606 people in 2017. The number of commercial insurance participants could not be unduplicated from the number of participants served in the public sector. When participants with commercial insurance and people served in the state mental health and correctional institutions are added to the public sector figures, an estimated 561,692 people received mental health services in 2017.



**Table 12: Mental Health Adult and Youth Participants Served in Wisconsin, 2022<sup>a</sup>**

<b>Wisconsin Programs Providing Mental Health Services</b>	<b>Adults Served (18+)</b>	<b>Youth Served (0-17)</b>	<b>Total Served</b>
Public County System	52,967	10,868	63,835
Medicaid Fee-for-Service	91,098	65,029	156,127
Medicaid Managed Care*	94,636	50,888	145,524
Medicaid Children’s Long-Term Care Severe Emotional Disturbance Waiver2*	0	1,277	1,277
Medicaid Milwaukee Wraparound/Dane Children Come First *	0	1,771	1,771
<b>Subtotal of Publicly-Funded Participants</b>	<b>238,701</b>	<b>129,833</b>	<b>368,534</b>
State Mental Health Institutions	3,186	741	3,921
Corrections*	12,736	122	12,858
Commercial Insurers <sup>b</sup> *	230,540	44,067	274,606
<b>Total Service Participants Served (partially unduplicated)<sup>c</sup></b>	<b>485,163</b>	<b>174,763</b>	<b>659,919</b>

a - See Appendix for multiple references.

b - Commercial insurance data are based on approximately 85% of commercial insurance companies.

c - The total number of people served is unduplicated across the county system and Medicaid-funded services. However, some duplication of clients served through other providers may exist.

\*Data is from 2017 as that was the more recent data available at time of application writing, updates will be provided at a later date.

Table 15 describes how many adult service participants received substance use services across different service sectors and funding sources in 2017. The same parameters for this data apply as described above for the mental health service participant data in Table 15. Very few youth receive substance use services, so only data on adults are included. Similar numbers of people access substance use services through the public system that DHS oversees (30,617) as access through Medicaid or medical assistance managed care programs (27,825) and Medicaid fee-for-service funded programs (33,024). When these groups are unduplicated, it reveals 70,267 service participants received services in the public system or were served with public funds. When the even larger group with commercial insurance who received services in 2017 is added, an estimated 118,722 received substance use services in 2017.

**Table 15: Substance Use Service Adult Participants Served, Wisconsin, 2022<sup>a</sup>**

<b>Wisconsin Programs/Agencies Providing Substance Use Services</b>	<b>Adults Served (18+)</b>
County Public System	20,175
Medicaid Fee-for-Service	20,898
Medicaid Managed Care*	33,024
<b>Subtotal</b>	<b>74,097</b>
State Mental Health Institutions	321
Corrections*	3,089
Commercial Insurers <sup>d</sup> *	45,102
<b>Total Service Participants Served (partially unduplicated)<sup>c</sup></b>	<b>122,609</b>

a - See Appendix for multiple references.

b - Commercial insurance data are based on approximately 85% of commercial insurance companies.

c - The total number of people served is unduplicated across the county system and Medicaid-funded services. However, some duplication of clients served through other providers may exist.

\*Data is from 2017 as that was the more recent data available at time of application writing, updates will be provided at a later date.

**Barriers to access**

Many adults with any mental illness or serious mental illness did not receive any mental health services according to the 2021 National Survey on Drug Use and Health.

Respondents from the same survey with an unmet mental health need cited the reasons why they did not access treatment (Table 16). Inability to afford the cost of treatment, a lack of knowledge of where to go for services and thinking that the individual could handle the problem without services were among the top reasons reported for not seeking services.

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**Table 16: Detailed Reasons for Not Receiving Mental Health Services in Past Year: Among People Aged 18 or Older with a Perceived Unmet Need for Mental Health Services in Past Year**

<b>Reason Did Not Receive Mental Health Services</b>	<b>Percent</b>
Could Not Afford Cost	40.1
Might Cause Neighbors/Community to Have Negative Opinion	10.6
Might have Negative Effect on Job	7.6
Health Insurance Does Not Cover Any Mental Health Services	8.1
Health Insurance Does Not Pay Enough for Mental Health Services	16.2
Did Not Know Where to Go for Services	30.0
Concerned About Confidentiality	11.6
Concerned About Being Committed/Having to Take Medicine	11.7
Did Not Feel Need for Treatment at the Time	11.4
Thought Could Handle the Problem Without Treatment	27.6
Treatment Would Not Help	12.1
Did Not Have Time	18.9
Did Not Want Others to Find Out	7.6
No Transportation/Inconvenient	5.1
COVID-19 Related	2.2
Some Other Reason	13.6

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

The National Survey on Drug Use and Health also asked individuals whether they had a substance use need, if they received treatment, and if they experienced barriers to accessing treatment. In the 2021 report, respondents who had an unmet substance use need for treatment cited the top 10 reasons for why they did not access treatment (Table 16). Similar to barriers to receiving mental health services, those in need of substance use services reported a top three barriers of inability to afford the cost of treatment, a lack of knowledge of where to go for services, and thinking that the individual could handle the problem without services.

**Table 16: Detailed Reasons for Not Receiving Substance Use Services in Past Year: Among People Aged 18 or Older with Past Year Any Substance Use Disorder and a Perceived Unmet Need for Substance Use Services in Past Year**

<b>Reason Did Not Receive Mental Health Services</b>	<b>Percent</b>
Could Not Afford Cost	43.2
Might Cause Neighbors/Community to Have Negative Opinion	11.6
Might have Negative Effect on Job	8.5
Health Insurance Does Not Cover Any Mental Health Services	9.0
Health Insurance Does Not Pay Enough for Mental Health Services	17.1
Did Not Know Where to Go for Services	31.1
Concerned About Confidentiality	12.8
Concerned About Being Committed/Having to Take Medicine	13.9
Did Not Feel Need for Treatment at the Time	10.8
Thought Could Handle the Problem Without Treatment	27.0
Treatment Would Not Help	12.7
Did Not Have Time	18.8
Did Not Want Others to Find Out	8.2
No Transportation/Inconvenient	6.2
COVID-19 Related	2.3
Some Other Reason	14.7

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration. Note: Among top 10 identified reasons

### **Service Workforce/Capacity**

#### **Psychiatrist shortages**

The DHS Primary Care Program is responsible for tracking health care professional shortages in Wisconsin, including psychiatrists, and coordinating federal grants targeted to address these shortages. The most recent available data on psychiatrist shortage areas is from March 2019 and is described below in Figure 11. For each county, the number of psychiatrist full-time equivalent positions that are needed to eliminate the shortage is calculated. A shortage designation can then be calculated to determine if an area can qualify for Health Professional Shortage Area federal funding. A significant shortage means having a ratio of 10,000 population to one full-time equivalent psychiatrist or higher. A 20,000 to one full-time equivalent ratio is required to qualify for a federal designation as a Health Professional Shortage Area and be eligible for federal benefits.

A summary of the highlights from the psychiatrist shortage data:

- All but six counties have some level of psychiatrist shortages.
- Although almost all rural areas have shortages of psychiatrists, larger counties have the largest shortages. The counties with the ten largest full-time equivalent shortages all have populations over 100,000 with the exception of St. Croix County. The counties with the largest shortages are Milwaukee, Outagamie, and Racine.

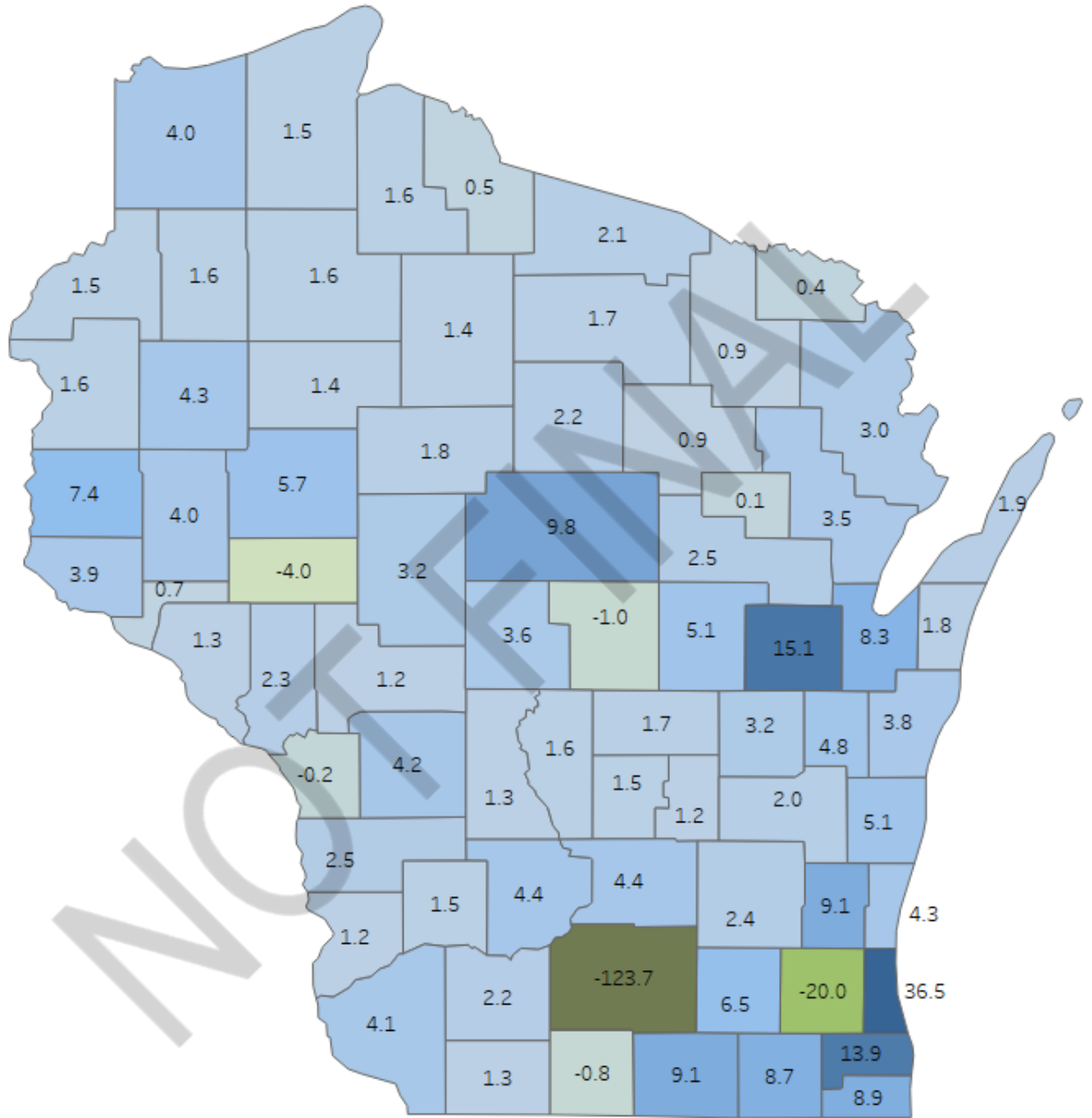
- Milwaukee County has a shortage of 36.5 full-time equivalent psychiatrists which is more than three times larger than the next county with a shortage.
- Of the six counties with an adequate supply of psychiatrists, all are counties with a large urban area with the exception of Green County.
- Waukesha and Dane are estimated to have a combined surplus of 144 psychiatrists with the majority of the surplus residing in Dane County.

Without the ability to relocate any full-time equivalent psychiatrists from where they are currently practicing, Wisconsin needs 117 more full-time equivalent psychiatrists statewide. However, if some psychiatrists were able to relocate from Dane and Waukesha counties, it is possible that the shortages could be eliminated. Although relocation for all surplus psychiatrists in these two counties is unlikely, the use of telehealth when appropriate could be used by psychiatrists in surplus areas to help address the need in shortage areas.

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Figure 11: Number of Psychiatrist Full-Time Equivalents Needed to Reduce Significant Shortages for the Resident Population, March 2019



Source: Office of Primary Care, DHS

## Needs and Priorities

Several key areas of need and services are highlighted via this section:

- Both nationally and in Wisconsin there continues to be an increase in behavioral health needs for adults and children. In particular the impacts of the COVID-19 pandemic are still being felt and in the coming years continued investment in behavioral health programs to serve people across the lifespan will be critical.
- Continued importance of supporting services for children and youth. This highlights the importance of key BPTR initiatives such as Comprehensive Services Teams, CCS, and systems of care to continue to expand and improve services for Children and Youth.
- Continued growth of the CCS program, which continues to be a key Medicaid funded services in Wisconsin, that continues to expand and serve move people in need across Wisconsin.
- Investments in the Crisis System continues through ongoing block grant efforts and the importance of such expansion is evident in the increased crisis system utilization by people across Wisconsin.
- Wisconsin continues to have a suicide rate higher than the national average and Wisconsin's rate in 2020 (14.5) was higher than it's been since 2017 (15.5). Although the suicide rate is higher in Wisconsin than the United States in general, this is especially true for the male population (30.27 for WI vs 27.6 for the US).
- Wisconsin's rate of past month alcohol use is higher than the national average and is the top substance people are being treated for in the public behavioral health system.
- Wisconsin's past year heroin use according to the most recent available data is higher than the national level, as is Wisconsin's past year pain reliever misuse.
- Disparities exist across race and ethnicity in opioid-related deaths in Wisconsin. From 2016-2021, American Indians had the highest rate of opioid-related deaths followed by Black individuals. Not only do these historically underserved populations have the highest rate of opioid-related deaths, their rate of death has also been increasing faster than other populations.
- There continues to be a need for more behavioral health providers across Wisconsin. Block grant efforts such as the expansion of Certified Peer Specialists and the Qualified Treatment Trainee program are key efforts to continue addressing these gaps.

**Appendix: Additional Data Source References**

Indicator	Source
<b>Public County System</b>	Wisconsin Department of Health Services, Division of Care and Treatment Services, Program Participation System
<b>Medicaid Fee-for-Service, Managed Care, Children’s Long-Term Care Severe Emotional Disturbance Waiver</b>	Wisconsin Department of Health Services, Division of Medicaid Services
<b>Medicaid Milwaukee Wraparound/Dane Children Come First</b>	Dane County Children Come First program, Milwaukee County Wraparound Initiative
<b>State Mental Health Institutions</b>	Wisconsin Department of Health Services, Division of Care and Treatment Services, Institution Insight System
<b>Corrections</b>	Wisconsin Department of Corrections
<b>Commercial Insurers</b>	Wisconsin Health Information Organization (WHIO)

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# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1  
**Priority Area:** Tuberculosis  
**Priority Type:** SUP, SUT  
**Population(s):** TB

**Goal of the priority area:**

Prevent tuberculosis (TB) transmission among people who inject drugs and treat those with tuberculosis.

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** A minimum of 98 percent of treatment agencies certified by DHS, Division of Quality Assurance (DQA) will be in compliance with TB screening, information, and referral requirements.  
**Baseline Measurement:** In CY 2021, DQA Behavioral Health Certification Services conducted 450 re-licensure surveys for Mental Health and Substance Use providers. Of those surveyed, 439 providers (97.5 percent) of providers were in compliance with TB screening/referral requirements.  
**First-year target/outcome measurement:** In CY 2022, 98 percent of treatment agencies will be in compliance with TB screening/referral requirements.  
**Second-year target/outcome measurement:** In CY 2023, 98 percent of treatment agencies will be in compliance with TB screening/referral requirements.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

**Priority #:** 2  
**Priority Area:** Persons Who Inject Drugs  
**Priority Type:** SUP, SUT  
**Population(s):** PWID

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

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

**Baseline Measurement:** In Calendar Year (CY) 2022, there were 2,049 persons in county-authorized services who reported injecting as a route of administration for rug use.

**First-year target/outcome measurement:** Assuming no change in national statewide trends of persons who inject drugs, the number of persons receiving county-authorized services who report injecting drugs will increase by at least two percent over the baseline level in CY 2023.

**Second-year target/outcome measurement:** Assuming no change in national statewide trends of persons who inject drugs, the number of persons receiving county-authorized services who report injecting drugs will increase by at least two percent over the baseline level in CY 2024.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 3

**Priority Area:** Youth Access to Tobacco Products

**Priority Type:** SUP

**Population(s):** PP, Other

**Goal of the priority area:**

Reduce youth tobacco use.

**Strategies to attain the goal:**

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

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** The proportion of successful purchases of tobacco products by youth will be below 10 percent, using unweighted data rates.

**Baseline Measurement:** In CY 2022, the unweighted Retailer Violation Rate (RVR) was 11.9 percent.

**First-year target/outcome measurement:** The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 10 percent during CY 2023.

**Second-year target/outcome measurement:** The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 10 percent during CY 2024.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 4

**Priority Area:** Pregnant Women and Women with Dependent Children

**Priority Type:** SUP, SUT

**Population(s):** PWWDC

**Goal of the priority area:**

Increase the number and quality of substance use disorder prevention, intervention, and treatment services for pregnant women and women with dependent children.

**Strategies to attain the goal:**

1) Provide training and technical assistance to counties, community-based providers and tribes to help them develop and implement evidence-based substance use programming and services serving pregnant women and women with dependent children. 2) Provide training and implement strategies for soundly-researched outreach models and interim services targeting pregnant women, including women from underserved and vulnerable populations. 3) Utilize at a minimum of 10 percent of the SUPTRS BG for the provision of treatment services for women's treatment.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** The number of counties, tribes, and community-based providers receiving training and technical assistance on implementing evidence-based practices and substance use treatment for pregnant women and women with dependent children.

**Baseline Measurement:** During SFY 2023, 26 counties, 8 tribes, and 186 community-based providers received training and training assistance on implementing evidence-based and substance use treatment for pregnant women and women with dependent children.

**First-year target/outcome measurement:** During SFY 2024, a minimum of five additional counties, tribes, and community providers will receive training and technical assistance implementing evidence-based practices and substance use treatment for pregnant women and women with dependent children.

**Second-year target/outcome measurement:** During SFY 2025, a minimum of five additional counties, tribes, and community providers will receive training and technical assistance implementing evidence-based practices and substance use treatment for pregnant women and women with dependent children.

**Data Source:**

DHS/DCTS records; training and fidelity forms and reports; County, Tribal, and community-based provider agency client records.

**Description of Data:**

Staff records of training and follow-up implementation and fidelity support provided to counties, tribes, and community-based providers.

**Data issues/caveats that affect outcome measures:**

N/A.

**Priority #:** 5

**Priority Area:** Primary Prevention Services

**Priority Type:** SUP

**Population(s):**

**Goal of the priority area:**

Prevent occurrences of substance misuse among vulnerable populations through the use of SUPTRS BG funds for primary prevention funds and activities.

**Strategies to attain the goal:**

(1) Require counties to spend at least 20 percent of their SUPTRS BG community aids award of primary prevention services. (2) Award contracts and grants to service providers to deliver primary prevention services. (3) Award contracts and grants to agencies to train and build capacity among the workforce and communities to deliver primary prevention services.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Wisconsin will spend at least 20 percent of its SUPTRS BG fund allocation on primary prevention services, training, and technical assistance.

**Baseline Measurement:** During SFY 2023, Wisconsin spent more than 20 percent of its SUPTRS BG expenditures on primary prevention services, training, and technical assistance.

**First-year target/outcome measurement:** During SFY 2024, Wisconsin will spend at least 20 percent of its SUPTRS BG expenditures on primary prevention services, training, and technical assistance.

**Second-year target/outcome measurement:** During SFY 2025, Wisconsin will spend at least 20 percent of its SUPTRS BG expenditures on primary prevention services, training, and technical assistance.

**Data Source:**

Department of Health Services Bureau of Fiscal Services (BFS) records of SUPTRS BG expenditures and the Division of Care and Treatment Services (DCTS) records of contractor activities.

**Description of Data:**

Program records from DCTS will be used to identify which contracts engage in primary prevention activities. Fiscal records will be used to determine how much money those programs spent during the fiscal year.

**Data issues/caveats that affect outcome measures:**

N/A.

**Priority #:** 6

**Priority Area:** Reduce Adult and Youth Binge Drinking

**Priority Type:** SUP

**Population(s):** PP, Other

**Goal of the priority area:**

Reduce the percentage of adults and youth binge drinking statewide.

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** In CY2021, 21.9 percent of adults in Wisconsin reported binge drinking within the past 30 days. Note: 2022 data is not yet available.

**First-year target/outcome measurement:** During CY2022, the percentage of adults who report binge drinking in the past 30 days will not exceed 21.7 percent.

**Second-year target/outcome measurement:** During CY2023, the percentage of adults who report binge drinking in the past 30 days will not exceed 21.5 percent.

**Data Source:**

National Survey on Drug Use and Health.

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

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

**Indicator #:** 2

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

**Baseline Measurement:** In CY2021, 5.1 percent of youth ages 12-17 reported binge drinking within the past 3- days

**First-year target/outcome measurement:** During CY2022, the percent of youth ages 12-17 who report binge drinking will not exceed 5.0 percent.

**Second-year target/outcome measurement:** During CY2021, the percent of youth ages 12-17 who report binge drinking will not exceed 4.9 percent.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 7

**Priority Area:** Opioid Misuse

**Priority Type:** SUT

**Population(s):** PWWDC, PWID

**Goal of the priority area:**

Reduce the number of opioid-related deaths in Wisconsin.

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** In CY 2021, there were 1,427 opioid-related deaths statewide.

**First-year target/outcome measurement:** During CY 2022, the number of opioid-related deaths statewide will not increase over the CY 2021 baseline of 1,427.

**Second-year target/outcome measurement:** During CY 2023, the number of opioid-related deaths statewide will not increase over the CY 2021 baseline of 1,427.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

CY 2022 was not yet finalized for use as a baseline. The data utilized in this measure covers calendar year as the annual number of opioid-related deaths across Wisconsin is measured by calendar year.

**Indicator #:** 2

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

**Baseline Measurement:** During CY 2022, 3,369 persons with an opioid-related substance use issue received county-authorized services.

**First-year target/outcome measurement:** During CY 2023, the number of persons receiving county-authorized services with an opioid-related substance use issue will increase by 5 percent over the 2022 baseline level.

**Second-year target/outcome measurement:** During CY 2024, the number of persons receiving county-authorized services with an opioid-related substance use issue will increase by 5 percent over the first-year level.

**Data Source:**

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

**Description of Data:**

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

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**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 8  
**Priority Area:** Stimulant Use Disorder  
**Priority Type:** SUP, SUT  
**Population(s):** PWWDC, PP, PWID

**Goal of the priority area:**

Expand intervention and treatment for stimulant use disorder.

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** The number of persons with a methamphetamine-related substance use issue who received county-authorized services annually.  
**Baseline Measurement:** During CY 2022, 2,286 persons with a methamphetamine-related substance use issue received county-authorized services.  
**First-year target/outcome measurement:** During CY 2023, the number of persons with a methamphetamine-related substance use issue receiving county-authorized services will increase by at least five percent over the baseline level.  
**Second-year target/outcome measurement:** During CY 2024, the number of persons with a methamphetamine-related substance use issue receiving county-authorized services will increase by at least five percent over the first year level.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 9  
**Priority Area:** Culturally-appropriate and Comprehensive Services for Underserved Populations  
**Priority Type:** SUP, SUT, MHS  
**Population(s):** SMI, SED, Other

**Goal of the priority area:**

Improve access to recovery-oriented, culturally-appropriate substance use services for underserved populations.

**Strategies to attain the goal:**

(1) Provide training, technical assistance, and consultation to service providers and underserved population communities to design services that are accessible, culturally appropriate, and comprehensive. (2) Promote participation in Emergent Leaders and Mentors training to members of underserved populations groups. (3) Incorporate National Standards of CLAS (Culturally and Linguistically Appropriate Services) into contracts and grant awards for counties, tribes, and service providers to implement in order to promote greater access to culturally responsive substance use treatment.

**Annual Performance Indicators to measure goal success**

<b>Indicator #:</b>	1
<b>Indicator:</b>	The number of planning sessions, cohorts, and graduates of the Emerging Leaders workforce development program to build diversity and capacity in leadership of community-based behavioral health services and workforce providing services within underserved communities.
<b>Baseline Measurement:</b>	In SFY 2023, the Emerging Leaders program held eight planning sessions, hosted two cohorts, and had 15 graduates.
<b>First-year target/outcome measurement:</b>	In SFY 2024, the Emerging Leaders program will hold a minimum of nine planning sessions and have a minimum of 16 graduates.
<b>Second-year target/outcome measurement:</b>	In SFY 2025, the Emerging Leaders program will hold a minimum of ten planning sessions and a have a minimum of 17 graduates.
<b>Data Source:</b>	DHS and DCTS staff records.
<b>Description of Data:</b>	Number of planning sessions and graduates of the Emerging Leaders workforce development program.
<b>Data issues/caveats that affect outcome measures:</b>	N/A.

**Priority #:** 10  
**Priority Area:** Behavioral Health Services in the Criminal Justice System  
**Priority Type:** SUT  
**Population(s):** Other

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

<b>Indicator #:</b>	1
<b>Indicator:</b>	The number of people who participated in a Treatment Alternative Program (TAP).
<b>Baseline Measurement:</b>	During CY 2022, 70 persons participated in a TAP.
<b>First-year target/outcome measurement:</b>	During CY 2023, the number of persons participating in a TAP will increase five percent over the baseline measure.



**Second-year target/outcome measurement:** During CY 2024, the number of persons participating in a TAP will increase five percent over the first year measure.

**Data Source:**

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

**Description of Data:**

TAP program administrative and client records.

**Data issues/caveats that affect outcome measures:**

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

**Priority #:** 11

**Priority Area:** Certified Peer Specialists

**Priority Type:** SUT, MHS

**Population(s):** SMI, SED

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Number of Certified Peer Specialists in Wisconsin.

**Baseline Measurement:** As of August 2023, there were 1368 Certified Peer Specialists in Wisconsin.

**First-year target/outcome measurement:** As of Sept. 2024, an additional 40 people, above baseline, will have become Certified Peer Specialists.

**Second-year target/outcome measurement:** As of Sept. 2025, an additional 40 people, above the first-year target, will have become Certified Peer Specialists.

**Data Source:**

Contract data provided by Certified Peer Specialist examination provider.

**Description of Data:**

Count of new people successfully achieving Certified Peer Specialist Certification.

**Data issues/caveats that affect outcome measures:**

**Indicator #:** 2

**Indicator:** Number of Certified Parent Peer Specialists in Wisconsin

**Baseline Measurement:** As of August 2023, there were 54 Certified Parent Peer Specialists in Wisconsin.

**First-year target/outcome measurement:** As of Sept. 2024, an additional 10 people, above baseline, will have become Certified

Parent Peer Specialists.

**Second-year target/outcome measurement:** As of Sept. 2025, an additional 10 people, above the first-year target, will have become Certified Parent Peer Specialists.

**Data Source:**

Contract data provided by Certified Peer Specialist examination provider.

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

**Priority #:** 12

**Priority Area:** Early Intervention for First Episode Psychosis

**Priority Type:** MHS

**Population(s):** SMI, ESMI

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:**

1

**Indicator:**

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

**Baseline Measurement:**

In FY 2022, 197 youth and young adults received CSC model services.

**First-year target/outcome measurement:**

In FY2024, an additional 15 youth and young adults will receive CSC model services above the baseline number served.

**Second-year target/outcome measurement:**

In FY2025, an additional 15 youth and young adults will receive CSC model services above the first-year target number served.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

A FY2022 baseline is used in this measure as it is the most complete number served at the time of this report writing. The baseline may be adjusted for outcome measurement once FY2023 numbers are collected.

**Priority #:** 13

**Priority Area:** Suicide Prevention

**Priority Type:** MHS

**Population(s):** SMI, SED

**Goal of the priority area:**

Prevent suicide and suicide attempts in Wisconsin.

**Strategies to attain the goal:**

1. Support and expand systems change approaches in health care settings serving individuals with SMI/SED to strengthen suicide prevention policies, procedures, and practices in those settings. 2. Support development of the mental health workforce through training in recognizing, assessing, managing, and responding to suicide risk in populations with SMI/SED.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** Four behavioral health organizations completed the Wisconsin Zero Suicide Training in Federal Fiscal Year 2023.

**First-year target/outcome measurement:** Four new behavioral health organizations will complete the Wisconsin Zero Suicide Training in Federal Fiscal Year 2024.

**Second-year target/outcome measurement:** Four new behavioral health organizations will complete the Wisconsin Zero Suicide Training in Federal Fiscal Year 2025.

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

**Priority #:** 14

**Priority Area:** Children's Mental Health

**Priority Type:** MHS

**Population(s):** SED

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** 41% of CST youth participants complete their services with "major or moderate" improvement at discharge (2022).

**First-year target/outcome measurement:** 42% of CST youth participants will complete their services with "major or moderate" improvement at discharge (2023).

**Second-year target/outcome measurement:** 43% of CST youth participants will complete their services with "major or moderate" improvement at discharge (2024).

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

**Priority #:** 15

**Priority Area:** Crisis Services

**Priority Type:** BHCS

**Population(s):** BHCS

**Goal of the priority area:**

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

**Strategies to attain the goal:**

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

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** As of August 2023, there are 250 people registered to become trained in mobile crisis team training.

**First-year target/outcome measurement:** As of October 2024, an additional 50 people, above baseline, will have been trained in at least one new training module.

**Second-year target/outcome measurement:** As of October 2025, an additional 30 people, above first-year target, will have been trained in at least one new training module.

**Data Source:**

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

**Description of Data:**

Count of registered persons completing training.

**Data issues/caveats that affect outcome measures:**

None

**Indicator #:** 2

**Indicator:** Expand the number of Wisconsin counties who have access to adult regional crisis

stabilization facilities and youth crisis stabilization facilities.

**Baseline Measurement:**

As of August 2023, 40% of Wisconsin counties have access to a youth crisis stabilization facility and 56% of counties have access to an adult regional crisis stabilization facility.

**First-year target/outcome measurement:**

As of October 2024, an additional 5% of counties, above baseline, will have access to an adult regional crisis stabilization facility.

**Second-year target/outcome measurement:**

As of October 2025, an additional 5% of counties, above first-year target, will have access to a youth crisis stabilization facility.

**Data Source:**

Contract data provided by contracted Youth Crisis Stabilization Facilities and Regionalized Crisis Stabilization Facilities.

**Description of Data:**

Number of Wisconsin counties who contract with youth crisis stabilization facilities and adult regional crisis stabilization facilities compared to total amount of Wisconsin counties.

**Data issues/caveats that affect outcome measures:**

None

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL

**Planning Tables**

**Table 2 State Agency Planned Expenditures [SUPTRS]**

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025. SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SUPTRS BG) <sup>a</sup>	J. ARP Funds (SUPTRS BG) <sup>b</sup>
1. Substance Use Prevention <sup>c</sup> and Treatment	\$41,331,902.00		\$297,738.00	\$30,208,558.00	\$14,001,266.00	\$21,890,702.00	\$0.00		\$7,657,075.00	\$0.00
a. Pregnant Women and Women with Dependent Children <sup>c</sup>	\$10,083,722.00		\$0.00	\$0.00	\$619,522.00	\$619,522.00	\$0.00		\$1,474,623.00	
b. Recovery Support Services	\$500,048.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
c. All Other	\$30,748,132.00		\$297,738.00	\$30,208,558.00	\$13,381,744.00	\$21,271,180.00	\$0.00		\$6,182,452.00	
2. Primary Prevention <sup>d</sup>	\$14,123,000.00		\$0.00	\$1,624,976.00	\$966,224.00	\$3,978,730.00	\$0.00		\$2,059,200.00	\$0.00
a. Substance Use Primary Prevention	\$14,123,000.00		\$0.00	\$1,624,976.00	\$966,224.00	\$3,978,730.00	\$0.00		\$2,059,200.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
6. Early Intervention Services for HIV	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	\$257,044.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$359,635.00	
<b>12. Total</b>	<b>\$55,711,946.00</b>	<b>\$0.00</b>	<b>\$297,738.00</b>	<b>\$31,833,534.00</b>	<b>\$14,967,490.00</b>	<b>\$25,869,432.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$10,075,910.00</b>	<b>\$11,008,294.00</b>

<sup>a</sup> The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>b</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

<sup>c</sup> Prevention other than primary prevention

<sup>d</sup> The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

**Planning Tables**

**Table 2 State Agency Planned Expenditures [MH]**

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SUPTRS BG) <sup>a</sup>	J. ARP Funds (MHBG) <sup>b</sup>	K. BSCA Funds (MHBG) <sup>c</sup>
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention <sup>d</sup>											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) <sup>e</sup>		\$2,964,000.00					\$400,000.00			\$2,500,000.00	
4. Other Psychiatric Inpatient Care			\$128,800,000.00								
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			\$35,800,000.00		\$229,600,000.00	\$107,000,000.00					
8. Other 24-Hour Care					\$7,000,000.00						
9. Ambulatory/Community Non-24 Hour Care		\$22,118,978.00	\$1,352,000,000.00	\$860,000.00	\$60,800,000.00	\$212,600,000.00	\$2,800,000.00			\$4,800,000.00	
10. Crisis Services (5 percent set-aside) <sup>f</sup>		\$4,000,000.00		\$3,788,000.00			\$600,000.00			\$7,800,000.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately <sup>g</sup>		\$540,000.00					\$50,000.00			\$18,000.00	
<b>12. Total</b>	<b>\$0.00</b>	<b>\$29,622,978.00</b>	<b>\$1,516,600,000.00</b>	<b>\$4,648,000.00</b>	<b>\$297,400,000.00</b>	<b>\$319,600,000.00</b>	<b>\$0.00</b>	<b>\$3,850,000.00</b>	<b>\$0.00</b>	<b>\$15,118,000.00</b>	<b>\$1,844,170.00</b>

<sup>a</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

<sup>b</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

<sup>c</sup>The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

<sup>d</sup>While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

<sup>e</sup>Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

<sup>f</sup>Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

<sup>g</sup>Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## Planning Tables

**Table 3 SUPTRS BG Persons in need/receipt of SUD treatment**

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

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

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,667	196
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	303,614	0
4. Persons who inject drugs	0	0
5. Persons experiencing homelessness	0	308

**Please provide an explanation for any data cells for which the state does not have a data source.**

1. Pregnant Women: 4,667 is representative of 7.7 percent of Wisconsin births 2. Women with Dependent Children: Data unavailable 3. Individuals with Co-Occurring MH/SUD: 303,614 is representative of 7.6 percent of Wisconsin's 18yo+ population. In treatment data unavailable 4. Persons who inject drugs: Data unavailable 5. Persons experiencing homelessness: Aggregate data unavailable

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**



# Planning Tables

## Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023      Planning Period End Date: 9/30/2024

FFY 2024			
Expenditure Category	FFY 2024 SUPTRS BG Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
1 . Substance Use Disorder Prevention and Treatment <sup>3</sup>	\$40,831,854.00	\$7,667,075.00	\$6,091,376.00
2 . Substance Use Primary Prevention	\$14,123,000.00	\$2,059,200.00	\$2,205,000.00
3 . Early Intervention Services for HIV <sup>4</sup>	\$0.00	\$0.00	\$0.00
4 . Tuberculosis Services	\$0.00	\$0.00	\$0.00
5 . Recovery Support Services <sup>5</sup>	\$500,048.00	\$0.00	\$1,978,624.00
6 . Administration (SSA Level Only)	\$257,044.00	\$359,635.00	\$733,294.00
<b>7. Total</b>	<b>\$55,711,946.00</b>	<b>\$10,085,910.00</b>	<b>\$11,008,294.00</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

<sup>3</sup>Prevention other than Primary Prevention

<sup>4</sup>For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

<sup>5</sup>This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Planning Tables

**Table 5a SUPTRS BG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2023      Planning Period End Date: 9/30/2024

Strategy	A		B	
	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
1. Information Dissemination	Universal	\$874,097	\$378,362	\$766,506
	Selected	\$13,676	\$9,082	\$3,664
	Indicated	\$14,185	\$1,390	\$561
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$901,958</b>	<b>\$388,834</b>	<b>\$770,731</b>
2. Education	Universal	\$7,505,431	\$419,846	\$419,376
	Selected	\$1,015,014	\$93,196	\$37,597
	Indicated	\$1,535,655	\$14,264	\$5,754
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$10,056,100</b>	<b>\$527,306</b>	<b>\$462,727</b>
3. Alternatives	Universal	\$1,003,925	\$11,856	\$4,783
	Selected	\$48,418	\$2,632	\$1,062
	Indicated	\$0	\$403	\$163
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$1,052,343</b>	<b>\$14,891</b>	<b>\$6,008</b>
4. Problem Identification and Referral	Universal	\$22,916	\$10,893	\$4,394
	Selected	\$0	\$2,418	\$975
	Indicated	\$7,550	\$370	\$149
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$30,466</b>	<b>\$13,681</b>	<b>\$5,518</b>
	Universal	\$0	\$957,017	\$146,487

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5. Community-Based Processes	Selected	\$59,368	\$80,602	\$782,517
	Indicated	\$235,593	\$12,336	\$4,977
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$294,961</b>	<b>\$1,049,955</b>	<b>\$933,981</b>
6. Environmental	Universal	\$1,784,943	\$31,505	\$12,710
	Selected	\$2,229	\$6,993	\$2,821
	Indicated	\$0	\$1,070	\$432
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$1,787,172</b>	<b>\$39,568</b>	<b>\$15,963</b>
7. Section 1926 (Synar)-Tobacco	Universal	\$0	\$0	\$0
	Selected	\$0	\$0	\$0
	Indicated	\$0	\$0	\$0
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
8. Other	Universal	\$0	\$19,878	\$8,019
	Selected	\$0	\$4,412	\$1,780
	Indicated	\$0	\$675	\$273
	Unspecified	\$0	\$0	\$0
	<b>Total</b>	<b>\$0</b>	<b>\$24,965</b>	<b>\$10,072</b>
<b>Total Prevention Expenditures</b>		<b>\$14,123,000</b>	<b>\$2,059,200</b>	<b>\$2,205,000</b>
<b>Total SUPTRS BG Award<sup>3</sup></b>		<b>\$55,711,946</b>	<b>\$10,085,910</b>	<b>\$11,008,294</b>
<b>Planned Primary Prevention Percentage</b>		<b>25.35 %</b>	<b>20.42 %</b>	<b>20.03 %</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

<sup>3</sup>Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

Footnotes:

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# Planning Tables

**Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2023      Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award <sup>1</sup>	FFY 2024 ARP Award <sup>2</sup>
Universal Direct	\$6,938,615	\$694,143	\$517,665
Universal Indirect	\$4,252,698	\$1,132,548	\$844,610
Selected	\$1,138,705	\$199,045	\$830,416
Indicated	\$1,792,982	\$30,464	\$12,309
<b>Column Total</b>	<b>\$14,123,000</b>	<b>\$2,056,200</b>	<b>\$2,205,000</b>
<b>Total SUPTRS BG Award<sup>3</sup></b>	<b>\$55,711,946</b>	<b>\$10,085,910</b>	<b>\$11,008,294</b>
<b>Planned Primary Prevention Percentage</b>	<b>25.35 %</b>	<b>20.39 %</b>	<b>20.03 %</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

<sup>3</sup>Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Planning Tables

**Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023    Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
<b>Prioritized Substances</b>			
Alcohol	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Fentanyl	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Prioritized Populations</b>			
Students in College	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQI+	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Persons Experiencing Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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## Planning Tables

**Table 6 Non-Direct-Services/System Development [SUPTRS]**

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023    Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated <sup>1</sup>	D. COVID-19 <sup>2</sup>	E. ARP <sup>3</sup>
1. Information Systems		\$32,000.00			\$1,000,000.00
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment		\$696,052.00			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation			\$62,002.00		\$687,916.00
7. Training and Education	\$442,270.00				
<b>8. Total</b>	<b>\$442,270.00</b>	<b>\$728,052.00</b>	<b>\$62,002.00</b>	<b>\$0.00</b>	<b>\$1,687,916.00</b>

<sup>1</sup>Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

<sup>2</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

<sup>3</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**


# Planning Tables

**Table 6 Non-Direct-Services/System Development [MH]**

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date:  MHBG Planning Period End Date:

Activity	FY Block Grant	FY <sup>1</sup> COVID Funds	FY <sup>2</sup> ARP Funds	FY <sup>3</sup> BSCA Funds
.	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<b>8. Total</b>			\$	\$



**Please wait while data loads...**

<sup>1</sup> The 24-month expenditure period for the COVID-19 Relief Supplemental Funding is **September 1, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. If you have approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

<sup>2</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

<sup>3</sup> The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 thru October 16, 2024** and for the 2nd allocation will be **September 30, 2023 thru September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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# Environmental Factors and Plan

## 1. Access to Care, Integration, and Care Coordination – Required

### Narrative Question

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

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: <https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001>; <https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983>. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.<sup>1</sup> Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:
  - a) Adults with serious mental illness
  - b) Pregnant women with substance use disorders
  - c) Women with substance use disorders who have dependent children
  - d) Persons who inject drugs
  - e) Persons with substance use disorders who have, or are at risk for, HIV or TB
  - f) Persons with substance use disorders in the justice system
  - g) Persons using substances who are at risk for overdose or suicide
  - h) Other adults with substance use disorders
  - i) Children and youth with serious emotional disturbances or substance use disorders
  - j) Individuals with co-occurring mental and substance use disorders

Wisconsin Department of Health Services continues to strive for increased access to care for mental health, substance use and co-occurring treatment. There is significant effort being placed on additional supports for treatment through funding related to block grants, state GPR, opioid settlement funds and discretionary grants. There has been additional support and development of peer services such as peer run respites, peer recovery centers, and a peer run warmline focused on supporting consumers with mental health and substance use needs. There has also been additional funding to support women's substance use residential treatment and an expansion of family centered services for substance use. Harm reduction efforts have expanded greatly in an attempt to address the opioid epidemic with additional supports for the distribution of naloxone, expansion of harm reduction vending machines and expansion of mobile medication units and lower level buprenorphine induction throughout WI. This year WI held a Children's System of Care Summit focused on development of an action plan to expand access to treatment for youth with serious emotional disturbance and/or substance use disorders and evidence based treatment has been emphasized in all populations. WI supported the roll out of 988 in an effort to expand access to crisis care and services and has focused much funding on the support and further development of Qualified Treatment Trainees to build the clinical workforce throughout the state. A strong emphasis on the development of a culturally diverse workforce has also been supported in an effort to increase access through the Emerging Leaders program and workforce development funding.

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

Wisconsin continues to work towards improved parity in partnership with the Division of Medicaid Services and the Office of the Commissioner of Insurance. Discussions were held specifically related to the understanding and move towards crisis coverage throughout the state and DCTS in partnership with DMS has rolled out the enhance mobile crisis response. Funding goes to support advocates and Disability Rights WI to support individuals with necessary treatment access and parity concerns throughout the state.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

- a) Access to behavioral health care facilitated through primary care providers
- b) Efforts to improve behavioral health care provided by primary care providers
- c) Efforts to integrate primary care into behavioral health settings

Through the State Opioid Response grant and partnership with FQHC's, WI continues to work towards integrated behavioral health and primary health care for individuals with mental health, substance use and co-occurring disorders. Wisconsin has supported the implementation of the state psychosocial rehabilitation benefit, Comprehensive Community Services, as well as increased access to crisis interventions by supporting partnerships with County behavioral health systems and FQHC's. There has also been an emphasis on expansion of the use of medication for opioid use disorder through education to primary care doctor's and support of low level buprenorphine induction in multiple clinics. Peer and recovery supports have been imbedded into hospital emergency departments (ED) to form connections to individuals with opioid use disorders seen in the ED. Wisconsin is also piloting a substance use disorder health home model focused on twelve core components of care in a hub and spoke model. This is a Medicaid funded pilot to expand access, integrated care and better practice for this complex population.

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

- a) Adults with serious mental illness
- b) Adults with substance use disorders
- c) Children and youth with serious emotional disturbances or substance use disorders

Care coordination is provided through numerous Medicaid program benefits as well as grant funding allocated to providers throughout WI. It is a required component of all of the psychosocial rehabilitation programs including Comprehensive Community Services and Community Support Programs, programs funded by Medicaid and provided by county human service agencies, as well as coordinated services teams and the wraparound model of care for children and youth, supported through contractual agreements with Counties and Tribes. Funding provided to counties, tribes and treatment providers is also able to support care coordination as a beneficial and supportive models for individuals with complex needs. Care Coordination is also a key element of the pilot substance use disorder health home model supporting in WI at this time.

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

Comprehensive Community Services, the state's psychosocial rehabilitation program funded by State GPR and Medicaid is an integrated mental health and substance use program provided by counties for individuals with complex needs that outpatient services are not able to meet. There are initiatives in the state, such as the Qualified Treatment Trainee support program, focused on training and education for supervisors and QTT's in relation to integrated treatment as well. WI, some time ago, passed acts that allowed for licenses mental health clinicians and those in training to provide substance use treatment without additional certifications within their scope of practice to expand integrated care. There is certification through DHS 75 that allows for the certification of integrated behavioral health clinics for co-occurring clinics and treatment expansion. This is similar for both the

adult and youth system.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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# Environmental Factors and Plan

## 2. Health Disparities - Required

### Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>1</sup>, [Healthy People, 2030](#)<sup>2</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>3</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the [Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)<sup>4</sup>.

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>5</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>6</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

<sup>1</sup> [https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS\\_Plan\\_complete.pdf](https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf)

<sup>2</sup> <https://health.gov/healthypeople>

<sup>3</sup> <https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf>

<sup>4</sup> <https://thinkculturalhealth.hhs.gov/>

<sup>5</sup> <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

<sup>6</sup> <https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf>

### Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

- a) Race  Yes  No
- b) Ethnicity  Yes  No
- c) Gender  Yes  No
- d) Sexual orientation  Yes  No
- e) Gender identity  Yes  No
- f) Age  Yes  No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?  Yes  No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  Yes  No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?  Yes  No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?  Yes  No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?  Yes  No
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The [National Center of Excellence for Integrated Health Solutions](#)<sup>1</sup> offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>2</sup>, The New Freedom Commission on Mental Health<sup>3</sup>, the IOM, NQF, and the [Interdepartmental Serious Mental Illness Coordinating Committee](#) (ISMICC)<sup>4</sup>.

One activity of the EBPRC<sup>5</sup> was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>6</sup> SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))<sup>7</sup> are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))<sup>8</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice



demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

<sup>1</sup> <https://www.thenationalcouncil.org/program/center-of-excellence/>

<sup>2</sup> United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>3</sup> The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

<sup>4</sup> National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

<sup>5</sup> <https://www.samhsa.gov/ebp-resource-center/about>

<sup>6</sup> <http://psychiatryonline.org/>

<sup>7</sup> <http://store.samhsa.gov>

<sup>8</sup> <https://store.samhsa.gov/?f%5B0%5D=series%3A5558>

**Please respond to the following items:**

- 1.** Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
- 2.** Which value based purchasing strategies do you use in your state (check all that apply):
- a)**  Leadership support, including investment of human and financial resources.
  - b)**  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)**  Use of financial and non-financial incentives for providers or consumers.
  - d)**  Provider involvement in planning value-based purchasing.
  - e)**  Use of accurate and reliable measures of quality in payment arrangements.
  - f)**  Quality measures focused on consumer outcomes rather than care processes.
  - g)**  Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h)**  The state has an evaluation plan to assess the impact of its purchasing decisions.
- 3.** Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## Environmental Factors and Plan

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

#### Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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

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

\* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

#### Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care (CSC)	3

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1482000	1482000

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

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

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?

Yes  No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

Yes  No

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

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

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Wisconsin plans to continue funding CSC model programs in FFY 2024 and FFY 2025. It is anticipated that all current providers will continue to receive funding in FFY 2024 and new sites will be identified through a competitive procurement process in FFY 2025.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

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

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

The estimated incidence rate of individuals who experience FEP each year in Wisconsin is approximately 3,480 from the general population, 663 young adults ages 15-24, and about 4,300 Medicaid recipients.

This is based on a population of 6 million (Wisconsin Department of Administration, 2022), about 771,000 young adults ages 15-24 (Office of Health Informatics, 2020), and Medicaid enrollment of approximately 1.6 million (Forward Health, 2022). The incidents rates used are as follows: median annual incidence rate of 58 per 100,000, young adult incidence rate of 86 per 100,000 (Simon, et al., 2017) and Medicaid population incidence rate of 272 per 100,000 (Radigan, et al., 2019).

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11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

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

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL

# Environmental Factors and Plan

## 5. Person Centered Planning (PCP) - Required for MHBG

### Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems <https://ncapps.acl.gov/home.html> with a systems assessment at [https://ncapps.acl.gov/docs/NCAPPS\\_SelfAssessment\\_201030.pdf](https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf)

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

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

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

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

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

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

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

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

As stated above, Wisconsin's three psychosocial rehabilitation programs invite consumer and family involvement, especially in the assessment, goalsetting, and planning process. With that, each program requires providers to receive training in Person-Centered Planning.

The Bureau has one contracted staff to provide Person-Centered Planning training and technical assistance to providers requesting it. Training and technical assistance about Person-Centered Planning is available to all Wisconsin DHS partners, including programs that don't explicitly require Person-Centered Planning.

Wisconsin's DHS outlines a model for Person-Centered Planning that includes practice measures of fidelity and guidance for the implementation of this model. In 2021, Wisconsin launched a virtual PCP training that is available on-demand to the public. The training is available at no-cost and self-paced. This ensures any mental health or substance use provider has access to timely, clear, and effective training on the critical elements of Person-Centered Planning. Agencies utilize this training for new hires and annual training for providers. Additional training and technical assistance are provided to programs who want it. In addition, Wisconsin utilizes its annual Mental Health and Substance Use Recovery Conference and bi-weekly educational webinar organized by the Wisconsin DHS Person-Centered Planning staff to promote the use of recovery-oriented services and programming, and Person-Centered Planning. Over 8100 providers, the majority of whom work in Wisconsin, are part of the educational webinar learning community.

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

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

Please indicate areas of technical assistance needed related to this section.

None needed at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Environmental Factors and Plan

## 6. Program Integrity - Required

### Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

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

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

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

### Please respond to the following:

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

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

### Footnotes:



# Environmental Factors and Plan

## 7. Tribes - Requested

### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>56</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

### Footnotes:



## Environmental Factors and Plan

### 8. Primary Prevention - Required SUPTRS BG

#### Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification and Referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - a)  Data on consequences of substance-using behaviors
  - b)  Substance-using behaviors
  - c)  Intervening variables (including risk and protective factors)
  - d)  Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - a)  Children (under age 12)
  - b)  Youth (ages 12-17)
  - c)  Young adults/college age (ages 18-26)
  - d)  Adults (ages 27-54)
  - e)  Older adults (age 55 and above)
  - f)  Cultural/ethnic minorities
  - g)  Sexual/gender minorities
  - h)  Rural communities
  - i)  Others (please list)

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

- a)  Archival indicators (Please list)
- Alcohol Outlet Density
  - Treatment Admissions
  - School Alcohol/Drug Related Suspensions and Expulsions
  - Arrests
  - Acts of Violence
- b)  National survey on Drug Use and Health (NSDUH)
- c)  Behavioral Risk Factor Surveillance System (BRFSS)
- d)  Youth Risk Behavioral Surveillance System (YRBS)
- e)  Monitoring the Future
- f)  Communities that Care
- g)  State - developed survey instrument
- h)  Others (please list)

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

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

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

SUPTRS BG funds are formula allocated through a statutory requirement that calculates the amount of funds that each county receives via Community Aids funding. At least 20 percent of the Community Aids funding must be allocated to primary prevention services.

6. Does your state integrate the National CLAS standards into the assessment step?  Yes  No

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

The Bureau of Prevention Treatment and Recovery (BPTR) within DHS' Division of Care and Treatment Services (DCTS) has identified CLAS standards as one of its five areas of focus in its Diversity, Equity, and Inclusion Action Plan. CLAS Standards are integrated in the assessment step. Additionally, Wisconsin has a CLAS Coordinator and has implemented CLAS Workgroups. Continuous staff development related to CLAS is on-going and processes are being put in place for grantees.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step?  Yes  No

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

The BPTR integrates the enhanced National CLAS Standards in the assessment step, including sustainability as part of Engagement, Continuous Improvement, and Accountability (Standards 9-15).

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?  Yes  No
  - a) If yes, please describe.  
The WI Department of Safety and Professional Services oversees the certification process for substance use disorder prevention specialists and prevention specialists in training.
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?  Yes  No
  - a) If yes, please describe mechanism used.  
DHS, DCTS administers five regional prevention training and technical assistance centers through the Alliance for Wisconsin Youth coalitions statewide to support capacity building activities for the primary prevention workforce.
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No
  - a) If yes, please describe mechanism used.
4. Does your state integrate the National CLAS Standards into the capacity building step?  Yes  No
  - a) If yes, please explain in the box below.  
The BPTR has identified CLAS standards as one of its five areas of focus in its Diversity, Equity, and Inclusion Action Plan. CLAS Standards are integrated in the capacity building step. Additionally, Wisconsin has a CLAS Coordinator and has implemented CLAS Workgroups. Continuous staff development related to CLAS is on-going and processes are being put in place for grantees.
5. Does your state integrate sustainability into the capacity building step?  Yes  No
  - a) If yes, please explain in the box below.  
The BPTR integrates the enhanced National CLAS Standards in the capacity step, including sustainability as part of Engagement, Continuous Improvement, and Accountability (Standards 9-15).
  - b) If no, please explain in the box below.

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Planning**

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?  Yes  No  N/A

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

- a)  Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- b)  Timelines
- c)  Roles and responsibilities
- d)  Process indicators
- e)  Outcome indicators
- f)  Cultural competence component (i.e., National CLAS Standards)
- g)  Sustainability component
- h)  Other (please list):
  
- i)  Not applicable/no prevention strategic plan

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

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

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

N/A

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG  Yes  No

primary prevention funds?

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

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

N/A

8. Does your state integrate the National CLAS Standards into the planning step?  Yes  No

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

The BPTR has identified CLAS standards as one of its five areas of focus in its Diversity, Equity, and Inclusion Action Plan. CLAS Standards are integrated in the planning step. Additionally, Wisconsin has a CLAS Coordinator and implemented CLAS Workgroups. Continuous staff development related to CLAS is on-going and processes are being put in place for grantees.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step?  Yes  No

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

The BPTR integrates the enhanced National CLAS Standards in the planning step, including sustainability as part of Engagement, Continuous Improvement, and Accountability (Standards 9-15).

b) If no, please explain in the box below.

N/A

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:  
Brochures, clearinghouse/ resource centers, health fairs, media campaigns, hotlines, speaking engagements.
  - b) Education:  
Education programs for youth, mentors, ongoing classroom sessions, parenting/family management, peer leaders/helpers.
  - c) Alternatives:  
Recreation activities, community service activities, community drop-in centers, drug and alcohol-free dances and parties, youth/adult leadership activities.
  - d) Problem Identification and Referral:  
In Wisconsin, counties and providers are required to screen individuals engaged in substance use behavior to determine whether their behavior can be mitigated through education or other assistance without the need for treatment. Section DHS 75.14 provides standards for community-based prevention substance use services. Specifically, DHS 75.14 (5) states:

Problem identification and stand-alone referral. The prevention service shall implement methods to identify individuals who have demonstrated at-risk behavior, such as illegal or age- inappropriate use of tobacco or alcohol, or first use of illicit drugs, and determine if the individual's behavior can be reversed through education. This strategy does not include activities designed to determine if a person is in need of treatment. Examples of activities that may be conducted and methods used in carrying out this strategy include the following:

- a. Employee assistance programs.
- b. Student assistance programs.
- c. Educational programs for individuals charged with driving while under the influence or driving while intoxicated.

**e)** Community-Based Processes:

Community and volunteer training, community team building, coalitions, and systemic planning.

**f)** Environmental:

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

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

**a)** If yes, please describe.

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

**4.** Does your state integrate National CLAS Standards into the implementation step?  Yes  No

**a)** If yes, please describe in the box below.

The BPTR has identified CLAS standards as one of its five areas of focus in its Diversity, Equity, and Inclusion Action Plan. CLAS Standards are integrated in the planning step. Additionally, Wisconsin has a CLAS Coordinator and implemented CLAS Workgroups. Continuous staff development related to CLAS is on-going and processes are being put in place for grantees.

**b)** If no, please explain in the box below.

**5.** Does your state integrate sustainability into the implementation step?  Yes  No

**a)** If yes, please describe in the box below.

The BPTR integrates the enhanced National CLAS Standards in the implementation step, including sustainability as part of Engagement, Continuous Improvement, and Accountability (Standards 9-15).

**b)** If no, please explain in the box below

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NOT FINAL

## Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification and Referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Evaluation

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

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

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

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

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

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

- a)  30-day use of alcohol, tobacco, prescription drugs, etc
- b)  Heavy use



- c)  Binge use
- d)  Perception of harm
- e)  Disapproval of use
- f)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- g)  Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step?  Yes  No

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

b) If no, please explain in the box below.

The BPTR is working towards implementing CLAS in all contracts and grant opportunities and is expecting to include CLAS in the evaluation step.

6. Does your state integrate sustainability into the evaluation step?  Yes  No

a) If yes, please describe in the box below.

The BPTR asks counties and providers to use the Strategic Prevention Framework (SPF) which includes sustainability.

b) If no, please explain in the box below.

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NOT FINAL

**Footnotes:**

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NOT FINAL

# Environmental Factors and Plan

## 9. Statutory Criterion for MHBG - Required for MHBG

### Narrative Question

#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

### Please respond to the following items

#### Criterion 1

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

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

1. Community Living Supportive Services: These services include activities intended to assure successful community living, such as meal planning/preparation, household cleaning, personal hygiene, medication reminders, medication side effect monitoring, parenting skills, and community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills.
2. Peer Support Services: These services include assistance from an individual who has lived the experience of mental illness and is trained to support others in their recovery journey.
3. Supported Employment Services: These services include activities to assist individuals to obtain and maintain competitive employment.

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

Comprehensive Community Services (CCS) is a program for individuals of all ages who need ongoing services for a mental illness, substance use disorder, or a dual diagnosis beyond occasional outpatient care, but less than the intensive care provided in a CSP or inpatient setting. The individual works with a dedicated team of service providers to develop a treatment and recovery plan to meet the individual's unique needs and goals. The goal of this community-based approach is to promote better overall health and life satisfaction for the individual. CCS became available to counties and tribes in Wisconsin in 2005. In 2014, the state provided counties and tribes a financial incentive to form regions to increase access to CCS and create efficiencies in administration. Presently, there are 25 certified regions. These regions cover 66 counties and three tribes. One county provides CCS in a non-regional model. Eligibility for CCS is determined through a screening process conducted by the county-based or tribal-based provider organization. This screening process is repeated annually to assess the individual's progress. CCS is built around proven treatment and support methods. The programs offered through CCS are designed to promote and support recovery by stabilizing and addressing an individual's critical mental health and substance use concerns, including an individual's ability to self-manage their physical and social health; and an individual's ability to meet their basic needs, including housing, education, and employment skills.

Coordinated Services Teams (CST) Initiatives are programs designed to provide wraparound support to children struggling to maintain their emotional, physical, and social well-being because of multiple and serious challenges in their lives. CST Initiatives are designed to develop a comprehensive, individualized system of care for children with complex behavioral health needs. The CST itself is a group that includes family members, service providers, and others that work to develop and carry out a coordinated services plan for the child. CST Initiatives are intended for children who are involved in multiple systems of care such as mental health, substance abuse, child welfare, juvenile justice, special education, or developmental disabilities.

These programs provide a robust system of community-based behavioral health services through Wisconsin's public behavioral

health system.

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

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

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

3. Describe your state's case management services

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

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

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

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

Please indicate areas of technical assistance needed related to this section.

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Criterion 2: Mental Health System Data Epidemiology

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

**Criterion 2**

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	6.0	<input type="text"/>
2.Children with SED	11.0	<input type="text"/>

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

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

Please indicate areas of technical assistance needed related to this section.

Wisconsin would be interested in learning how other states calculate statewide incidence.

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NOT FINAL

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care\*?

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

Please indicate areas of technical assistance needed related to this section.

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

[https://gucchd.georgetown.edu/products/Toolkit\\_SOC\\_Resource1.pdf](https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf)

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Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

- a. Describe your state's targeted services to rural population. [See SAMHSA's Rural Behavioral Health page for program resources](#)

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

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

The use of TeleHealth in Wisconsin has been increasing to help address the need for an array of mental health and substance use services. Psychiatry services in particular are lacking in many rural areas. To help address these barriers Wisconsin supports a Child Psychiatry Consultation Program to provide support to physicians. In this model the primary care physician provides direct patient care supported by a child psychiatric consultant.

- b. Describe your state's targeted services to people experiencing homelessness. [See SAMHSA's Homeless Programs and Resources for program resources](#)

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

Through the Division of Housing in the Department of Administration (DOA) programs such as HOME Tenant Based Rental Assistance (TBRA), HUD -funded Emergency Solutions Grant (HEARTH 24 CFR part 91 and 576) and state-funded shelter, transitional living, and homelessness prevention grants, Wisconsin provides a range of services to those who are homeless or are at risk of homelessness. Additionally, Wisconsin's initiatives in SSI/SSDI Outreach, Access and Recovery (SOAR) have assisted many homeless and disenfranchised individuals obtain urgently needed disability and insurance benefits which help support a life off the street. Having related medical insurance greatly improves access to medical and behavioral health treatment.

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

- c. Describe your state's targeted services to the older adult population. [See SAMHSA's Resources for Older Adults webpage for resources.](#)

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

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

Please indicate areas of technical assistance needed related to this section.

## Criterion 5: Management Systems

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

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

## Criterion 5

## a. Describe your state's management systems.

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

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

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

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

Wisconsin uses telehealth across the majority of mental health services in the state. During the pandemic, many flexibilities were created to assist providers to use telehealth when services could be offered in a manner similar to a face-to-face interaction. During the past year as the pandemic ended, these flexibilities were written into program administrative code and Medicaid policy as permanent allowable services in most program areas.

Please indicate areas of technical assistance needed related to this section.



**Footnotes:**

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# Environmental Factors and Plan

## 10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

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

### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/residential)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Services for special populations:

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

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**Criterion 2**

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NOT FINAL

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

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

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

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
- a) 90 percent capacity reporting requirement  Yes  No
- b) 14-120 day performance requirement with provision of interim services  Yes  No
- c) Outreach activities  Yes  No
- d) Syringe services programs, if applicable  Yes  No
- e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
2. Has your state identified a need for any of the following:
- a) Electronic system with alert when 90 percent capacity is reached  Yes  No
- b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
- c) Use of peer recovery supports to maintain contact and support  Yes  No
- d) Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?  Yes  No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Within DCTS, the staff designated as the State Opioid Authority and staff within the Substance Use Services Section, receive notification of 90 percent capacity and provision of interim services from providers across the state. In addition, DCTS receives annual reports from counties that require them to address whether they are complying with the various SUPTRS BG requirements, and what corrective steps were taken to meet compliance in instances where counties previously fell out of compliance. In addition to ensuring that counties have processes in place for reporting wait lists and capacity, these requirements are communicated in contracts and via ongoing communication from DCTS.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
- a) Business agreement/MOU with primary healthcare providers  Yes  No
- b) Cooperative agreement/MOU with public health entity for testing and treatment  Yes  No
- c) Established co-located SUD professionals within FQHCs  Yes  No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

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

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

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?  Yes  No
2. Has your state identified a need for any of the following:

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

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)?  Yes  No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program?  Yes  No

If yes, please provide a brief description of the elements and the arrangement

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NOT FINAL

**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of services for:
    - i) MOUD  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  Yes  No
2. Does your state provide any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) An organized referral system to identify alternative providers?  Yes  No
  - c) A system to maintain a list of referrals made by religious organizations?  Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No

- c) Identify workforce needs to expand service capabilities  Yes  No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

**Patient Records**

- 1. Does your state have an agreement to ensure the protection of client records?  Yes  No
- 2. Has your state identified a need for any of the following:
  - a) Training staff and community partners on confidentiality requirements  Yes  No
  - b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
  - c) Updating written procedures which regulate and control access to records  Yes  No
  - d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure:  Yes  No

**Independent Peer Review**

- 1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
- 2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
  - a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.  
Five to six block grant sub-recipients are reviewed each year.
- 3. Has your state identified a need for any of the following:
  - a) Development of a quality improvement plan  Yes  No
  - b) Establishment of policies and procedures related to independent peer review  Yes  No
  - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No
- 4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No
  - If Yes, please identify the accreditation organization(s)**
  - i)  Commission on the Accreditation of Rehabilitation Facilities
  - ii)  The Joint Commission
  - iii)  Other (please specify)

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**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  Yes  No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  Yes  No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state  Yes  No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  Yes  No
  - c) Performance-based accountability:  Yes  No
  - d) Data collection and reporting requirements  Yes  No
2. Has your state identified a need for any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs  Yes  No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services  Yes  No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  Yes  No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  Yes  No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
  - a) Prevention TTC?  Yes  No
  - b) Mental Health TTC?  Yes  No
  - c) Addiction TTC?  Yes  No
  - d) State Targeted Response TTC?  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C. § 300x-32 (f)).*

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women  Yes  No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis  Yes  No
  - b) Early Intervention Services Regarding HIV  Yes  No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment  Yes  No

b) Professional Development

Yes  No

c) Coordination of Various Activities and Services

Yes  No

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

[https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030)

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

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**Footnotes:**

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NOT FINAL

## Environmental Factors and Plan

### 11. Quality Improvement Plan- Requested

#### Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

#### Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023?  Yes  No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

#### Footnotes:

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NOT FINAL

## Environmental Factors and Plan

### 12. Trauma - Requested

#### Narrative Question

**Trauma**<sup>1</sup> is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>2</sup> paper.

<sup>1</sup> Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

<sup>2</sup> *Ibid*

#### Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?  Yes  No
4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
6. Does the state use an evidence-based intervention to treat trauma?  Yes  No
7. Does the state have any activities related to this section that you would like to highlight.

State provides on average 45-50 trauma-informed training events each year. Since 2014 19,000 clinicians statewide of been trained in trauma, trauma-informed approaches and its connection to M/SUD issues. State supports and participates in the planning of conferences that highlight trauma in M/SUD issues. The state provides a monthly listserv that highlights the latest interventions and information on trauma, resilience, and trauma-informed care. Current listserv subscriptions are close to 20,000. State has created training videos and content for first responders and "helping the helpers" as part of the Resilient Wisconsin initiative.

Please indicate areas of technical assistance needed related to this section.

No technical assistance needed at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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## Environmental Factors and Plan

### 13. Criminal and Juvenile Justice - Requested

#### Narrative Question

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More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.<sup>1</sup> Almost two thirds of people in prison and jail meet criteria for a substance use disorder.<sup>2</sup> As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.<sup>3</sup> States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

<sup>1</sup>Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

<sup>2</sup>Bronson, J., Strop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

<sup>3</sup>Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." *Journal of the American Academy of Child and Adolescent Psychiatry* 47(3):282–90.

**Please respond to the following items**

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- Coordination across mental health, substance use disorder, criminal justice and other systems
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system?  Yes  No  
If so, please describe.

In collaboration with Wisconsin Department of Corrections and the Division of Community Corrections, the SSA supports a Peer Specialist program that centers on strength-based and individualized care. The program provides clients assistance in recovery and substance that are involved in the criminal justice system. Peer specialists visit home, reach out by phone or virtual calls to regularly communicate with those they serve. The peer specialist assists participants in identifying specific and relevant community resources related to client recovery and support linked to reducing recidivism. Services delivered are culturally responsive and specific to gender diversity. These programs focus on Certified Peer Specialists who have lived experience with mental health and substance use disorders and with a background in the criminal justice system. In addition, majority of individuals in prison in Wisconsin identify as BIPOC.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No

4. Does the state have any activities related to this section that you would like to highlight?

The SSA coordinates policymaking with the State Criminal Justice Coordination Council to assist with diversion for individuals with substance use and mental health issues who are involved with or have had contact with the criminal justice system. We provide an advisory position to the Wisconsin Association of Treatment Court Professionals providing evidence base care and best practices



for treatment for co-occurring disorder individuals involved in the criminal justice system.

Partnering with WI Department of Justice's (DOJ's), SSA and SMHA collaborate to provide Evidence Based decision Making Initiative to work on diversion and use of evidence-based practices (EBPs).

The SSA & SMHA is involved with working in partnership with 84 local Treatment Courts statewide (with another 5-7 counties and tribes in the process of developing programs) and continue to assist in the process of developing programs with county tribes along with the WI Department of Justice and WI Department of Corrections (DOC) providing clinical consultation and support for use of and incorporation of evidence-based practices. With this partnership it provides technical assistance on the use of EBP's in the full continuum of services for substance treatment and recovery services. The SSA supports the integration and ongoing training for a trauma informed response to the criminal justice client to support evidence-based practices and decrease risk for traumatization with our partners in DOJ, DOC, peer support specialists and community providers who serve this population.

In addition, SSA and SMHA staff the Criminal Justice Committee within the WI council on Mental Health. Staff also provide an advisory role representing Wisconsin Association of Treatment Court Professionals. The Committee has encouraged the state legislature and governor to support efficient and seamless access by reentering persons to community mental health and substance use services: housing employment, medical care, as well as access to Badger Care, Medicaid, and other benefits for supporting services.

Other programs and services that the SSA supports through funding or technical assistance or otherwise collaborates with include: (1) substance use disorder treatment in the women's correctional institution, and juvenile correctional institutions; (2) community – based SUD services for person on reentry or at halfway houses as they return to their communities; (3) Juvenile justice gang diversion program that features SUD prevention, treatment and education services with emphasis on cognitive behavior treatment and trauma informed techniques; (4) the county treatment alternative programs that provides treatment in lieu of jail, working closely with drug courts, county district attorney's and judges. (5) approximately 90 problem solving courts operation across the state, including OWI, adult drug, veteran, tribal healing to wellness, and mental health courts; (6) the state – funded prison reintegration program that assist Milwaukee County residents in transitioning back home, addressing both housing and substance use disorder(s). (7) 14 Medication assisted treatment programs in the state which allow for injections prior to leaving the jail and subsequent treatment with a community substance use provider and case management services to assist applying for Medicaid (8) the state-funded Treatment Alternatives and Diversion (TAD Program that provides alternatives to prosecution and incarceration for criminal offenders who abuse alcohol and other drugs.

Please indicate areas of technical assistance needed related to this section.

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## Environmental Factors and Plan

### 14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

#### Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?
  - a) Wisconsin utilized General Profit Revenue, Opioid Settlement, and State Opioid Response Grant funding to develop and implement a total of 12 mobile opioid treatment program units (four units in 2022 and eight in 2023). These mobile units are focused to increase access to MAT to communities in rural and high-risk areas. Each unit is designed to dispense all three forms of FDA approved MOUD and clinical services. The first mobile OTP is anticipated to be deployed for services in early August 2023.
  - b) In July 2023 the Wisconsin Society of Addiction Medicine (WISAM) was awarded with settlement funding to develop and implement a pilot project to utilize telephonic/telehealth Buprenorphine allowances for individuals to access MOUD. WISAM will

be able to connect individuals to treatment and prescribers around the state with assistance of certified peer support specialist and recovery coaches.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL

## Environmental Factors and Plan

### 15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

#### Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

*....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*

*CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*

- Crisis call centers
- 24/7 mobile crisis services
- Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.

*STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes "[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)" as well as an [Advisory: Peer Support Services in Crisis Care](#) and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "[National Guidelines for Child and Youth Behavioral Health Crisis Care](#)" which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

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

In Wisconsin, Crisis Intervention, administered under DHS 34, subchapter III administrative rule, is available through three modalities, at minimum: 24/7 telephone services; 8 hours per day, 5-day per week walk-in service; and 8-hour per day, 7-day per week mobile services, including mobile crisis outreach. Programs certified under subchapter III are eligible to claim reimbursement for service provision through Wisconsin Medicaid through an established fee-for-service rate structure and private insurers as well (Wisconsin administrative rule requires Crisis Intervention Services to be covered under Casualty Insurance: INS 3.37). Most of Wisconsin's 72 counties are under an umbrella of DHS 34, subchapter III programs, either as a certified entity themselves or by contracting with a

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

a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA

guidelines.

d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

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

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

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

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

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

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Someone to respond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Safe place to go or to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Briefly explain your stages of implementation selections here.

- 1) Someone to talk to – Majority Implementation - 90% of Wisconsin counties have certified crisis programs and operate 24/7 crisis lines allowing persons in crisis to get quickly connected to local, county based resources when in crisis.
- 2) Someone to respond – Majority Implementation – 94.12% of Wisconsin counties have certified crisis programs which requires them to operate mobile crisis programs at the minimum standard of 24 hours a day 7 days a week. Many counties, especially those in larger counties with more access to resources offering expanding mobile crisis services, including co-responder models, mobile crisis teaming

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Wisconsin continues to develop and enhance the state's crisis system based on the Crisis Now model and guidelines developed by SAMHSA. The 988 Wisconsin Lifeline is a primary area of focus as it's often the initial touchpoint for individuals in crisis. With mobile crisis response available in most of the state there is focus on enhancement of these services which include mobile crisis teaming response, response in rural and underserved areas or underserved populations, 24/7 response, and enhanced follow-up. Crisis stabilization efforts in Wisconsin are being enhanced through regionalized approaches to address geographical service gaps and improve access, this includes youth crisis stabilization.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

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

Please indicate areas of technical assistance needed related to this section.

Technical assistance related to sustainable funding for 988 is a need.

Please indicate areas of technical assistance needed related to this section.

Technical assistance related to sustainable funding for 988 is a need.



OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

**Please respond to the following:**

1. Does the state support recovery through any of the following:
  - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
  - b) Required peer accreditation or certification?  Yes  No
  - c) Use Block grant funding of recovery support services?  Yes  No
  - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  Yes  No
2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.  
For adults with SMI Wisconsin has a wide variety of recovery support services as listed below: Clubhouses, peer run recovery centers, peer run respite, certified integrated peer specialists, certified parent peer specialists. The peer run recovery implementation task force that focuses on advising DCTS/BPTR and the Certified Peer Specialist Advisory Committee that both advises DCTS/BPTR on peer specialist and parent peer specialist services, on peer initiatives, the peer recovery education, dual disorder education, health care integration, peer run warmline, certified peer specialists in crisis services, self-directed care, shared decision making, person-centered planning. Peers often work as co-trainers with DCTS staff on several training initiatives including but not limited to trainings on recovery and person-centered planning. In addition to the peer run supports and services, NAMI Wisconsin and their affiliate local organizations are also a primary source of recovery supports for people with mental illness and their families.

Wisconsin has support services offered through schools for children with SED in many areas. These can be in the form of NAMI supported groups and/or the training of Honest, Open, Proud in schools and communities to support youth in the decision regarding the telling of their story. There is also support provided in the state for parents of children with SED from other parents through advocacy and support agencies such as Wisconsin Family Ties and NAMI.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations  
Wisconsin has a wide variety of recovery support services that are listed below and are accessible for individuals with SMI and SUD: Peer run recovery centers, peer-run respite, certified integrated peer specialists, certified parent peer specialists, peer-run recovery advisory task force that focuses on peer specialist, peer recovery education, dual disorder education, health care integration, peer run warmline, recovery organizations, peer recovery coaching provided to individuals who have suffered an opioid overdose in the ER, peer recovery coaching, person-centered planning, self-care and wellness approaches, support for women and their children while in treatment, and county-funded SUD treatment that includes room and board. In addition, Wisconsin has a well-developed network of Alcoholics Anonymous and Narcotics Anonymous meetings across the state.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**



## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:
  - Housing services provided  Yes  No
  - Home and community-based services  Yes  No
  - Peer support services  Yes  No
  - Employment services.  Yes  No
2. Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

#### Footnotes:

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>1</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>2</sup> For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.<sup>3</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>4</sup>

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.<sup>5</sup>

According to data from the 2017 Report to Congress<sup>6</sup> on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

<sup>1</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>2</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>3</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>4</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>5</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

<sup>6</sup> [http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

1. Does the state utilize a system of care approach to support:
- a) The recovery of children and youth with SED?  Yes  No
  - b) The resilience of children and youth with SED?  Yes  No
  - c) The recovery of children and youth with SUD?  Yes  No
  - d) The resilience of children and youth with SUD?  Yes  No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
- a) Child welfare?  Yes  No
  - b) Health care?  Yes  No
  - c) Juvenile justice?  Yes  No
  - d) Education?  Yes  No
3. Does the state monitor its progress and effectiveness, around:
- a) Service utilization?  Yes  No
  - b) Costs?  Yes  No
  - c) Outcomes for children and youth services?  Yes  No
4. Does the state provide training in evidence-based:
- a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - b) Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
5. Does the state have plans for transitioning children and youth receiving services:
- a) to the adult M/SUD system?  Yes  No
  - b) for youth in foster care?  Yes  No
  - c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?  Yes  No
  - d) Does the state have an established FEP program?  Yes  No
  - Does the state have an established CHRP program?  Yes  No
  - e) Is the state providing trauma informed care?  Yes  No
6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)
- a) In 2023, Wisconsin held a Children’s System of Care Summit. The purpose of the summit was to engage, equip, and empower counties and tribes in the evolution of their children’s system of care. The summit was divided into three parts – inspire, inform, and implement. Prior to the summit, a tremendous amount of data collection was conducted and then this data was carefully

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evaluated. The summit participants included individuals with lived experience, peer services, counties, tribal nations, primary care, providers, advocates, and state representatives from child welfare, youth justice, education, corrections, and behavioral health. The summit laid the foundation to the development of a statewide children's system of care strategic plan which is expected to be completed in early 2024. This plan will be monitored by the Children Come First Advisory Committee which is a committee mandated in legislation. The plan will be implemented across the children's system of care and routine reporting of progress will be made.

b) Wisconsin has guidelines for individualized care planning. Wisconsin builds plans of care for children and youth based on information obtained from the Child and Adolescent Needs and Strengths (CANS) tool. The team and the family are involved in discussing each child's strengths and needs and prioritizing them. Once the top needs have been agreed upon, the development of the care plan begins with the identification of a long-term goal. The team then determines short-term goals, objectives, and tasks, and identifies the person responsible, timeline, and funding source for each goal. Plans of care must be updated every six months. In addition, crisis response plans for each child/youth are also required.

c) Our approach is rooted in the Systems of Care and Wraparound core values which includes Family and Youth Driven, Community Based, and Culturally and Linguistically Competent; for Wisconsin, we add Unconditional to the core values.

**7.** Does the state have any activities related to this section that you would like to highlight?

Wisconsin has been working towards creating a more seamless comprehensive children's behavioral health system and expanding work in the system of care after technical assistance was received by Georgetown University in 2015. The initial steps in this work included work to move the Wisconsin systems of care framework forward by infusing the Coordinate Services Teams (CST) Initiatives framework and best practices for working with children and families within Comprehensive Community Services (CCS) Program.

The work has evolved to include a system of care self-assessment tool that tribal nations and counties can use to assess where they are at in the development of their local system of care. The tribes and counties use this information to develop a plan to improve specific areas of need. Additionally, this information is used by the state to make data-driven decisions in the provision and development of technical assistance. The tool is a published document that has been used by other states in the assessment of their local systems of care.

The state has also developed a resource library that serves as a companion to the self-assessment tool. The work that was done at the Georgetown Implementation Academy has been continued with the work that was done at the Children's System of Care Summit in 2023. From this summit, a statewide children's system of care strategic plan will be completed in early 2024. Wisconsin has been invited to present at national conferences related to children's system of care as well as consult with other states on their own evolution and development.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

#### Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

The following MHBG-funded activities are intended to improve services and reduce suicide in the state:

a) Support the systems change approach (e.g., Zero Suicide framework) to prevent suicide for individuals receiving services in health or behavioral health care settings.

b) Develop the mental health workforce through training in recognizing, assessing, managing, and responding to suicide risk.

c) Support a 988 member center that provides statewide coverage for 988.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

If yes, please describe how barriers are eliminated.

NA

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted?  Yes  No

If so, please describe the population of focus?

The crisis services set-aside currently goes toward 988 services in the state. The state's 988 service provider follows suicide protocol language required by Vibrant Emotional Health (the national 988 administrator), such as screening questions, and uses an evidence-based safety planning tool (Stanley-Brown Safety Planning Intervention) for delivering services to individuals with suicide risk.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

#### Footnotes:

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

DHS has a long history of collaboration and coordination with other state agencies in Wisconsin. These include the Department of Public Instruction, Department of Children and Families, Department of Corrections and Department of Justice to name a few. These cooperative agencies often work to eliminate silos and support initiatives focused on improved mental health and substance use treatment, including access to care, throughout the state. The agencies often partner on new initiatives, budget requests, planning and discretionary grants, such as Project Aware, to enhance efficiency, effectiveness and quality of care

throughout WI.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL



## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>1</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>1</sup><https://www.samhsa.gov/grants/block-grants/resources> [samhsa.gov]

#### Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Wisconsin Council on Mental Health (WCMH) is directly involved in the development and review of state behavioral health plans and initiatives through ongoing conversations at the Council's bi-monthly meetings and ongoing committee meetings. . During the WCMH July meeting, staff from the BPTR provided an overview of the block grant program and an overview of the '24-'25 plan and application. A draft of the application was also provided directly to the members of the WCMH to provide feedback on an ongoing basis.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The state uses several mechanisms to plan and implement these services. This includes strategic planning at both the Department, Division, and Bureau level, utilizing data and evaluation to ensure the effectiveness of programs, and implementing new programs, evidence based practices, and initiatives. Advisory groups such as the WCMH, the State Council on Alcohol and Other Drug Abuse, and partners at the county behavioral health level also provide feedback and guidance in the planning and implementation of behavioral health services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

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

The WCMH and committees regularly invite outside advocacy groups, researchers, and members of the public to attend, provide information, and comment at their meetings. Members of the WCMH and committees regularly meet with DHS leadership and



State lawmakers to discuss behavioral health needs and services in Wisconsin. The WCMH reviews state and federal mental health legislation and communicates with legislators on behalf of people in recovery, consumers, and families.

The State Council on Alcohol and Other Drug Abuse (SCAODA) is statutorily mandated to provide statewide leadership and coordination on substance use disorder issues. SCAODA is responsible for reviewing pending legislation, developing a four-year plan to implement its priorities, reviewing the biennial budget, and making recommendations to the governor and legislature. SCAODA has five standing committees—the Executive Committee, the Diversity Committee, the Intervention and Treatment Committee, the Prevention Committee, and the Planning and Funding Committee. The Diversity Committee has a standing subcommittee on the deaf, deaf/blind, and hard of hearing and a standing subcommittee on cultural competency; the Intervention and Treatment Committee has a standing subcommittee on Children, Youth, and Families; and the Prevention Committee has a standing subcommittee on epidemiology. SCAODA from time to time establishes ad hoc committees.

During 2022-2023, the WCMH and the SCAODA both made efforts to study and learn more about how the two Councils can make an impact on addressing inequity, racism, and underserved populations and created Access and Equity workgroups. The WCMH invited speakers from several agencies and organizations that provide services to underserved populations. Both the SCAODA and WCMH have formed workgroups to address diversity, equity, and inclusion.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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NOT FINAL

# Environmental Factors and Plan

## Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

- State Education Agency
- State Vocational Rehabilitation Agency
- State Criminal Justice Agency
- State Housing Agency
- State Social Services Agency
- State Health (MH) Agency.
- State Medicaid Agency

Start Year: 2024      End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kemba Banyard	Providers			
Christine Barnard	Others (Advocates who are not State employees or providers)			
Jerolynn Bell-Scaggs	Providers			
Jessica Boling	State Employees			
Kimberlee Coronado	Parents of children with SED			
Nic Dibble	Others (Advocates who are not State employees or providers)			
Mark Eisner	State Employees			
Svea Erlandson	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Jennifer Farmbrough	Parents of children with SED			
Richard Ferrari-Traner	State Employees			
Dennis Hanson	Providers			
Pam Lano	State Employees			
Matt MacLean	Others (Advocates who are not State employees or providers)			
Mary Madden	Others (Advocates who are not State employees or providers)			
Brian Michel	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Phung Nguyen	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Karen Odegaard	State Employees			

Tim Peerenboom	State Employees			
Dawn Shelton-Williams	Others (Advocates who are not State employees or providers)			
Sheryl Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Ana Winton	Others (Advocates who are not State employees or providers)			

\*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

State Education Agency - Tim Peerenboom

State Vocational Rehabilitation Agency - Mark Eisner

State Criminal Justice Agency - Currently Vacant

State Housing Agency - Jessica Bolling

State Social Services Agency - Richard Ferrari Traner

State Health (MH) Agency. - Karen Odegaard

State Medicaid Agency - Pam Lano

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# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	4	
Parents of children with SED	2	
Vacancies (individual & family members)	4	
Others (Advocates who are not State employees or providers)	6	
<b>Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others</b>	<b>16</b>	<b>64.00%</b>
State Employees	6	
Providers	3	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>9</b>	<b>36.00%</b>
Individuals/Family Members from Diverse Racial and Ethnic Populations	6	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
<b>Total Membership (Should count all members of the council)</b>	<b>25</b>	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## Environmental Factors and Plan

### 22. Public Comment on the State Plan - Required

Narrative Question

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

#### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
  - a) Public meetings or hearings?  Yes  No
  - b) Posting of the plan on the web for public comment?  Yes  No  
If yes, provide URL:  
<https://www.dhs.wisconsin.gov/wcmh/mhbg.htm> and <https://www.dhs.wisconsin.gov/scaoda/index.htm>  
If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:
  - c) Other (e.g. public service announcements, print media)  Yes  No  
Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

## Environmental Factors and Plan

### 23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction<sup>1,2</sup> on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act, 2018](#) (P.L. 115-141) signed by President Trump on March 23, 2018<sup>3</sup>.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers<sup>4</sup>. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs<sup>5</sup>: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf> ,
2. **Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf> ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

## End Notes

<sup>1</sup> Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

<sup>2</sup> Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

<sup>3</sup> Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

<sup>4</sup> Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

<sup>5</sup> ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

Wisconsin does utilize funding to support prevention and outreach programs through provision of staff for harm reduction, overdose prevention, and disease prevention services. Funded services include providing educational information and promotion, support, and navigation to connect individuals to MH and SUD services along with HIV, Viral Hepatitis A and B, STD, and TB screening and referral for testing and medical treatment as indicated. Funding is utilized to provide Naloxone and supplies exclusive of needles/syringes.

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## Environmental Factors and Plan

### Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

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