Wisconsin

DRAFT

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/16/2021 7.43.20 PM)

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

NOT FINAL

State Information

DRAFT

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 036448835

Expiration Date

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

NOT FINAL

State CMHS DUNS Number

Number 03644835

Expiration Date

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

DRAFT

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	
Email Address	Ryan.Stachoviak@wisconsin.gov

NOT FINAL

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

DRAFT

Fiscal Year 2022

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

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

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

DRAFT

ASSURANCES - NON-CONSTRUCTION PROGRAMS

DRAFT

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 nineteen 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 with the 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).

DRAFT

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 of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

DRAFT

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
   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.

DRAFT

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.

DRAFT

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.

DRAFT

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: Julie A. Willems Van Dijk

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

DRAFT

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 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**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

DRAFT

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 nineteen 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 with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

DRAFT

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 of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

DRAFT

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
   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.

DRAFT

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.

DRAFT

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.

DRAFT

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: Julie A. Willems Van Dijk

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

DRAFT

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

Standard Form LLL (click here)

Name

Julie A. Willems Van Dijk

Title

Deputy Secretary

Organization

Wisconsin Department of Health Services

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

DRAFT

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, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

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 abuse 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 has implemented SUD residential treatment services over the past year. 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

NOT FINAL

DRAFT

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 in an effort to reduce the need for inpatient treatment and reduce the disruption hospitalization can cause to the consumer and their family. Discharge planning and a strong aftercare community mental health system are required to be initiated on the day of a consumer's admission. Such planning is essential to ensuring the length of the hospital stay is kept at a minimum, assuring minimal re-admissions, and promoting recovery.

Substance 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 new RSUD benefit is

NOT FINAL

DRAFT

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 new 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).

Medication Assisted Treatment (MAT) 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 Abuse Block Grant (SABG) 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 and to the Menominee Tribe to support comprehensive behavioral health promotion, including substance use disorder prevention efforts.

Milwaukee Child Protection Services Substance Abuse Services
DHS also provides funding to the Department of Children and Families to provide substance abuse prevention as part of child welfare services for families affected by substance abuse.

Alliance for Wisconsin Youth Regional Prevention Centers
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.

NOT FINAL

DRAFT

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 its consumers.

Urban Youth Primary Substance Use Prevention
DHS funds alcohol and drug prevention efforts targeting youth in grades K-12 in four counties or tribes. This program used to be called Inner City Youth SU Program.

Injection Drug Use Prevention
Wisconsin devotes SABG 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
SABG 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. SABG funds are also used to support a prevention specialist to assist with program delivery and evaluation.

Program evaluation
Entities receiving SABG 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
SABG 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 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

NOT FINAL

DRAFT

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 Milwaukee County provider to reduce substance abuse in specific cultural 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 abuse 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 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 SABG funds a small portion the services. Currently, 68 counties and all 11 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 SABG 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 soundly researched best practices in treatment for methamphetamine use for county residents who are stuggling with drug addiction.

NOT FINAL

DRAFT

Department of Corrections SU Treatment
DHS funds various programs within the Department of Corrections, including alcohol and drug abuse 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 recovery organizations, 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 22 opioid treatment programs that use medication-assisted treatment. In 2015, Wisconsin established three opioid treatment centers, funded with state general purpose revenue, to

NOT FINAL

DRAFT

serve rural, underserved areas of the state in northern and central Wisconsin that provide Office-Based Opiate Treatment (OBOT) services. In early 2018, an additional four providers received state funds to operate regional opioid treatment centers; these centers are also authorized to treat methamphetamine addiction.

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.

Helpline and Hotline Assistance
In addition, DHS partnered with other state agencies and the University of Wisconsin to launch 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. The outpatient rule was revised in 2009 to allow for more flexibly rendered services and most recently revised to ensure licensed psychotherapists can practice independently.

Comprehensive Community Services (CCS)
Unlike other 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 are able to provide feedback to the CCS program regarding policies, practices, and procedures that are recovery-oriented and person-centered. Services

NOT FINAL

DRAFT

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, 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

NOT FINAL

DRAFT

(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, 68 counties and all 11 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 in an effort to help them achieve mental health stability and to complete school and obtain employment.

NOT FINAL

DRAFT

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 age 17 and under who meet different federal target groups, including physical disabilities, SED, and developmental disabilities. For children with SED, the eligibility age extends out to age 21. Aside from age and disability, the CLTS wavier requires that the child live at home but require services at the level of care typical to an intermediate care facility for 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)

Wisconsin subcontracts with three agencies to provide CSC for First Episode Psychosis model programs in Wisconsin. 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. That program provides CSC services to nine counties throughout Northwestern Wisconsin. Wisconsin plans to expand CSC programs through a funding opportunity in 2021-2022.

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.

NOT FINAL

DRAFT

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 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.

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 in particular 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

NOT FINAL

DRAFT

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

A current effort of the BPTR is the implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards. The BPTR had previously developed and implements a training plan for CLAS education and training within the Division of Care and Treatment Services, the Department of Health Services, and external partners and providers. A BPTR staff member has been certified as a train the trainer of CLAS and has provided training to the DCTS staff members.]The BPTR has begun including language in contracts regarding CLAS Standards to encourage additional implementation of these standards.

The Wisconsin DHS has also made strategic planning on diversity, equity, and inclusion a priority. The Bureau of Prevention Treatment of Recovery has also hired a consultant to help the Bureau address health inequity and diversity. Moreover, the DCTS is in the process of hiring a Diversity, Equity, and Inclusion position to support Division-wide efforts.

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

NOT FINAL

DRAFT

leaders. The program is designed to give emerging leaders of the state's four minority 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 minority 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.

NOT FINAL

Planning Steps

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

DRAFT

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care 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 M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

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 a recurring Needs Assessment process to inform future policy and funding decisions. A primary use of the Needs Assessment is to help guide program development, and Substance Abuse and Mental Health Block Grant implementation. The Needs Assessment is also used more broadly to inform ongoing DCTS and local program and funding decisions. The most recent data available is 2019 unless otherwise indicated.

The 2019 Wisconsin Mental Health and Substance Abuse Needs Assessment Report[1] was published in October of 2020. This report was complemented by a separate report, the 2019 Behavioral Health Gaps Report for the State of Wisconsin[2], published in October of 2020. While the traditional Needs Assessment relies on existing historical data, the Gaps Report utilized the knowledge and experience of stakeholders in the behavioral health system. Through interviews, surveys, and focus groups, the study asks not only what needs and gaps exist in the system, but also what the solutions are to address them.

More details pertaining to this section can be found in the attached Needs Assessment and Gaps Report.

Prevalence of Mental Health Needs

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 overall national rates of any mental illness and serious mental illness have increased slightly in the last two years, but not significantly.
- National trends show adults ages 18-25 and individuals who are currently employed full-time have an increasing rate of mental health needs relative to other groups. The increase from 2015 to 2017 in any mental illness for these two groups is the only significant change in prevalence among the different demographic groups in the below table.
- Multi-racial and unemployed individuals have relatively higher rates of mental health needs.
- Wisconsin adults rank higher than several other states on the prevalence of serious mental illness.
- Wisconsin adults ages 18-25 rank higher than many other states on all three prevalence indicators and especially for prevalence of major depressive episode.

Estimating the prevalence of mental health needs in the youth population is difficult. The above adult rates were generated from surveys and interviews conducted as part of the annual National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration. However, the National Survey on Drug Use and Health assesses a narrow component of youth mental health called major depressive episode, which is defined as a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of

[1] Wisconsin Department of Health Services, Wisconsin Mental Health and Substance Abuse Needs Assessment Report (2019). https://www.dhs.wisconsin.gov/publications/p00613-19.pdf.
[2] Vigna, A.J., Connor, T. The 2019 Behavioral Health Gaps Report for the State of Wisconsin. Madison, WI: University of Wisconsin Population Health Institute, October 2020. https://uwphi.pophealth.wisc.edu/publications-2/evaluation-reports-2/.

NOT FINAL

DRAFT

specified depression symptoms. Because major depressive episode is narrowly defined, it cannot be used to estimate the total prevalence of youth mental health needs throughout the state.

Adult Mental Health Prevalence – 2015 and 2017 National Rates

Demographic Characteristic	Any Mental Illness		Serious Mental Illness	
	2015	**2017**	**2015**	**2017**
TOTAL	17.9	18.9	4	4.5
AGE				
18-25	21.7	25.8**	5	7.5
26-49	20.9	22.2	5	5.6
50 or Older	14	13.8	2.8	2.7
GENDER				
Male	14.3	15.1	3	3.3
Female	21.2	22.3	5	5.7
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino				
White	19.3	20.4	4.5	5.2
Black or African American	15.4	16.2	2.9	3.5
American Indian or Alaska Native	21.2	18.9	6.3	5.1
Native Hawaiian or Pacific Islander	14.8	19.4	1.8	4.8
Asian	12	14.5	1.7	2.4
Two or More Races	29.5	28.6	9.5	8.1
Hispanic or Latino	14.5	15.2	2.9	3.2
CURRENT EMPLOYMENT				
Full-Time	15.4	17**	3.1	3.7**
Part-Time	20.3	22.1	4.5	5.6
Unemployed	24.5	26.6	6	7.5
Other	19.7	19.4	4.9	5

NOT FINAL

DRAFT

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.***Statistically significant difference from a smaller value on 2016 National Survey on Drug Use and Health survey year (.01 level).*

Mental Health Prevalence Indicators for Wisconsin - 2017

Wisconsin	12-17 years	18-25 years	26+ years	18+ years – All Adults
	Percent			
Major Depressive Episode	13.66	13.99[a]**	6.44	7.5
Serious Mental Illness	--	7.53[b]**	4.45[b]	4.88[b]
Any Mental Illness	--	25.53[b]	17.4	18.54

Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration. *a - Top 20 percent rate across all states*, *b - Top 20-40 percent rate across all states. **Statistically significant increase from the 2016 National Survey on Drug Use and Health survey results (.01 level).*

Specific Population Prevalence Rates

The below table highlights specific population groups known to have high rates of mental health needs that are above 25 percent. These groups and their rankings have not changed much in the past decade.

Population Groups with Highest Prevalence Rates

Population Group	**Any Mental Illness Prevalence Rate (% of population)**
County Jails	64.0
Corrections (Adults)	50.1
Substance Use Disorder (Adults)	45.6
Homeless	45.0
Lesbian, Gay, or Bisexual (LGB)	37.4
Two or More Races	28.6
Unemployed	26.6
Age 18-25	25.8
Poverty	25.6

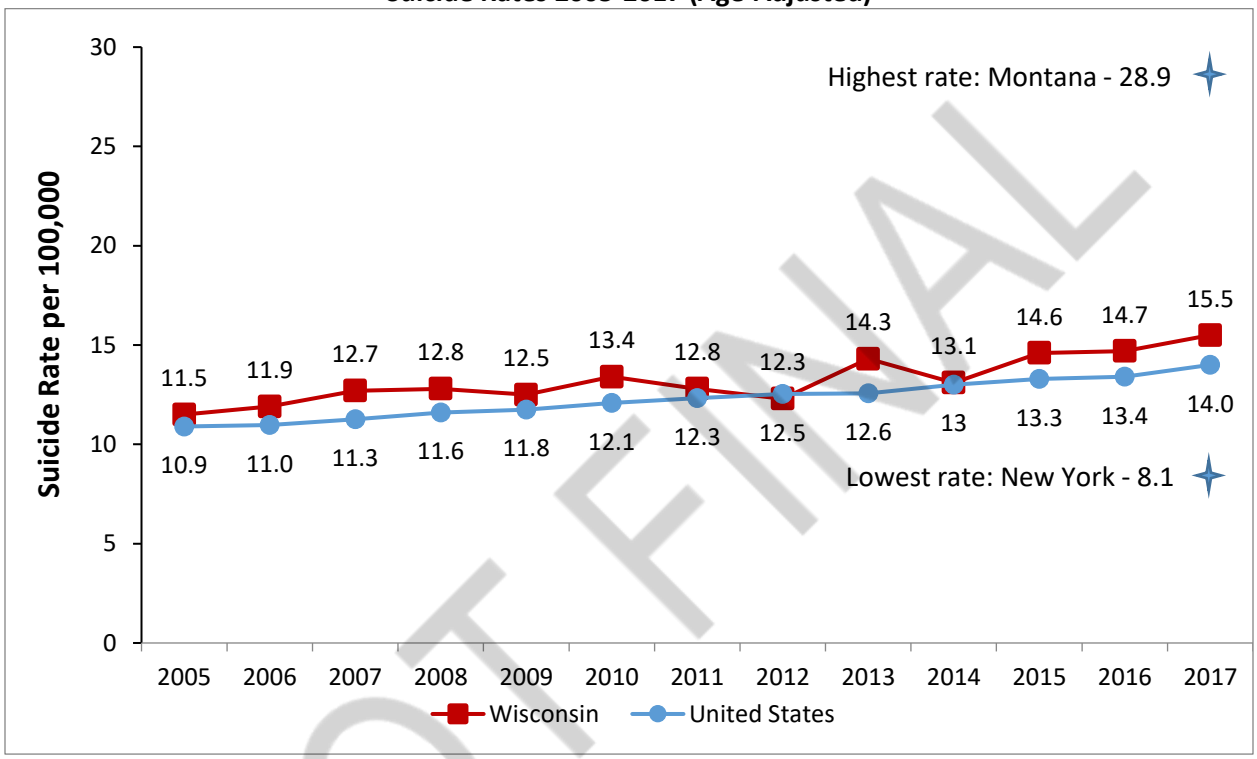
NOT FINAL

DRAFT

Priority Highlight: Suicide

Wisconsin has had a suicide rate slightly higher than the national average over the last 13 years and calendar year 2017 was no different as illustrated the below figure. 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 2017 was not only the highest it's been since 2005 (15.5), the gap with the national rate was the largest it's been since 2005 with the exception of 2013.

Suicide Rates 2005-2017 (Age-Adjusted)



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

In addition to the comparison of the overall Wisconsin and national rates, other notable Wisconsin suicide rate trends per 100,000 people include:

- Wisconsin's suicide rate was higher in 2017 than the average Midwestern state rate (15.5 vs. 14.8) and was also higher every other year since 2005 with the exception of 2012.
- Wisconsin residents in rural counties with less than 50,000 people had a higher suicide rate (15.5) in the 2013-2017 period than residents in urban counties (14.6).
- When metro and non-metro areas are defined regardless of county boundaries, an even greater rural-urban disparity exists (16.6 vs. 15.1 in 2017). The national gap was even greater in 2017 when non-metro areas had a rate of 19.2 compared to 13.2 for metro areas. While the national rural-urban disparity has grown since 2005, Wisconsin's disparity has narrowed slightly from a difference in suicide rates of 2.6 to 1.5.
- Wisconsin's racial and ethnic minority groups are too small to examine suicide rate annual trends over time reliably. However, when 2013-2017 are combined to provide reliable comparisons amongst groups, American Indians (15.6) and Caucasians (15.3) have significantly higher rates than Blacks (5.3), Asians (6.5), and Hispanics (6.2).

NOT FINAL

DRAFT

Access to Mental Health Services

Individuals served in both public and private systems are included in analyses below. 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. The treatment gap for mental health services will be examined below first followed by the substance use treatment gap.

While many service participants (71,150) 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 (125,072) 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. For example, 46 percent of participants served in the county service system used Medicaid fee-for-service and 25 percent used Medicaid managed care to fund at least some of their services. 270,771 participants received services in the public service systems or were served with public funds.

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.

Mental Health Adult and Youth Participants Served in Wisconsin, 2017[a]

Wisconsin Programs Providing Mental Health Services	**Adults Served (18+)**	**Youth Served (0-17)**	**Total Served**
Public County System	58,673	12,477	71,150
Medicaid Fee-for-Service	91,124	33,948	125,072
Medicaid Managed Care	94,636	50,888	145,524
Medicaid Children's Long-Term Care Severe Emotional Disturbance Waiver	0	1,277	1,277
Medicaid Milwaukee Wraparound/Dane Children Come First	0	1,771	1,771

NOT FINAL

DRAFT

Unduplicated Subtotal of Publicly-Funded Participants	**188,815**	**81,143**	**269,958**
State Mental Health Institutions	2,545	912	3,457
Corrections	12,736	122	12,858
Commercial Insurers[b]	230,540	44,067	274,606
Total Service Participants Served (partially unduplicated)[c]	**434,636**	**126,244**	**560,879**

a - See Needs Assessment 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.

Adults and youth tend to access mental health services differently. In the adult mental health system, 53 percent access services using commercial insurance compared to only 34 percent of youth. Due to their dependent status, youth rely more heavily on Medicaid funding for accessing services. Fifty-four percent of youth used Medicaid funds for their mental health services in 2017 and 64 percent relied on Medicaid-funded and/or county-provided services.

Subtracting these figures from the number of individuals estimated to have any mental illness in 2017 in the Prevalence of Needs section of this report:

- The overall treatment gap is 46 percent, or 468,581 individuals annually.
- The overall adult treatment gap is 47 percent, or 393,965 adults annually.
- The overall youth treatment gap is 37 percent, or 74,616 youth annually.

Mental Health Service Workforce/Capacity

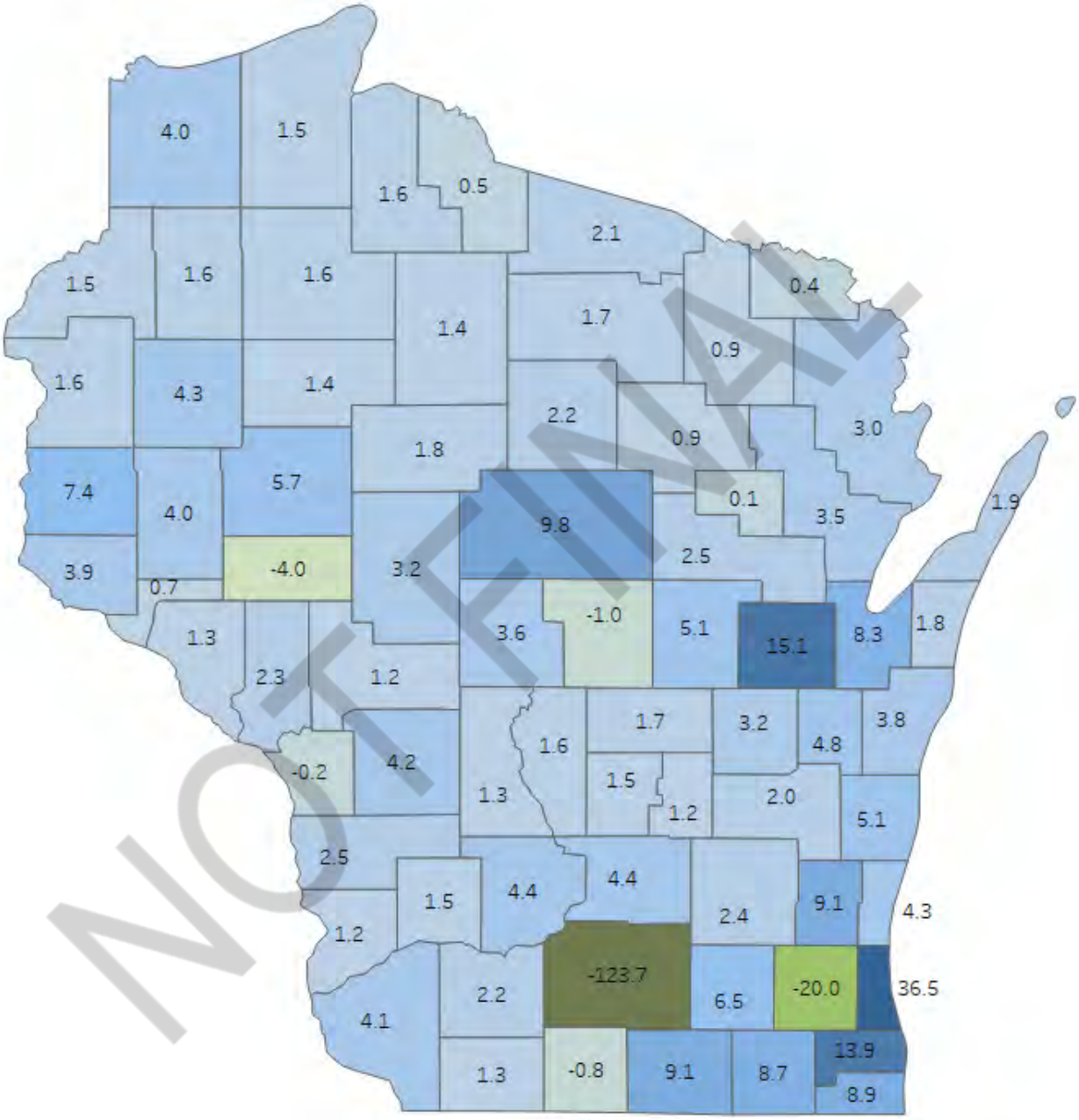
Mental health services providers certified by the DHS Division of Quality Assurance include providers that perform inpatient, psychosocial rehabilitation services, outpatient, day treatment, and other types of services.

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 in the next figure. 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.

NOT FINAL

DRAFT

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



Source: Office of Primary Care, DHS

A summary of the highlights from the psychiatrist shortage data includes:

- 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

DRAFT

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.

The use of certified peer specialists, including Integrated Certified Peer Specialists, and Certified Parent Peer Specialists, to expand the capacity of the Wisconsin mental health system has grown exponentially in recent years. Certified peer specialists cannot only increase the capacity of an agency's workforce, they can also improve the quality and effectiveness of treatment by establishing a collaborative, trusting relationship between the provider agency and the individuals receiving services.

The Prevalence of Substance Use Needs

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. Wisconsin's rate of substance use disorder exceeds the national rate for both adults ages 18 and older and youths ages 12-17. The rate of past month alcohol use is Wisconsin is higher than the national average. Additionally, the rate of past year cocaine use has increased significantly in Wisconsin from the 2015-2016 combined survey to the 2016-2017 combined survey.

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. The substance use disorder prevalence rate off the population group of Corrections (Adults) is 56% and 34.7% for individuals experiencing homelessness as well as 35.1% in the population group of Corrections (Juveniles).

Wisconsin Substance Use Disorder in the Past Year, by Age, 2016-2017

Measure	2015-2016		2016-2017	
	Wisconsin	U.S.	Wisconsin	U.S.
Substance Use Disorder, 18+	9.1%	7.9%	8.5%	7.7%
Substance Use Disorder, 12-17	5.2%	4.6%	4.2%	4.1%

Printed: 8/16/2021 7:43 PM - Wisconsin - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

DRAFT

Source: 2017 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

Substance Use, by Substance, Age 12+, 2016-2017

Measure	2015-2016		2016-2017	
	Wisconsin	U.S.	Wisconsin	U.S.
Past month alcohol use	60.9%	51.2%	60.6%	51.2%
Past year marijuana use	12.2%	13.7%	12.7%	14.5%**
Past year cocaine use	1.4%	1.8%	2.0%**	2.0%**
Past year heroin use	0.3%	0.3%	0.4%	0.3%
Past year pain reliever misuse	4.0%	4.5%	3.8%	4.2%**
Past year opioid misuse*	3.3%	4.6%	--	--

Source: 2015-2017 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 2016-2017 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).*

Data derived from the Wisconsin Department of Health Services County Services Substance Use dashboard indicate that in 2020 the five most common substance people received treatment for were alcohol, marijuana, opioids, cocaine, and amphetamines.

Population Group Prevalence Estimates

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. The table below shows the prevalence rates of individuals having a substance use disorder for selected target populations.

NOT FINAL

DRAFT

Population Groups with Highest Prevalence

Population Group	Substance Use Disorder Prevalence Rate (% of population)
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

NOT FINAL

Priority Highlight: Opioids

Since the early 2000s, Wisconsin has been experiencing a surge in opioid misuse and its related harmful consequences. 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.

Opioid Use in the Past Year, Age 12+, 2015-2016

Measure	Wisconsin	U.S.	Midwest
Past Year Opioid Misuse	3.3%	4.6%	4.3%

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

DRAFT

Opioid Use in the Past Year, Age 12+, 2015-2016, (Rates per 1,000 Population)

Measure	Wisconsin	U.S.
Past Year Opioid Use Disorder	7.40	8.41
Past Year Opioid Use Disorder and Did Not Receive Treatment at a Specialty Facility	6.98	6.65

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.

Wisconsin Opioid Prescriptions

Prescription Indicator	2014	2015	2016	2017	2018
Individuals Obtaining an Opioid Prescription	1,148,713	1,137,214	1,076,501	964,638	872,222
Prescriptions Dispensed	5,081,327	5,014,011	4,709,813	4,062,133	3,569,147
Average Prescriptions Filled Per Person Obtaining an Opioid Prescription	4.23	4.40	4.37	4.21	4.09

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

In 2018, 70 of Wisconsin's 72 counties have ambulance runs where naloxone is administered. According to the DHS ambulance run data system, there were 3,791 ambulance runs in 2018 across Wisconsin where naloxone was administered. This is a slight decrease since 2015 (3,857 ambulance runs with naloxone administration). This may be due to the increasing availability of naloxone through community organizations.

NOT FINAL

DRAFT

The below table displays some disparities across race and ethnicity in opioid-related deaths out of the Wisconsin population. From 2015-2017, American Indians have the highest rate of opioid-related deaths followed by Black individuals.

Drug Overdose Deaths Involving Any Opioid by Race or Ethnicity, Wisconsin, 2012-2014 and 2015-2017 Combined (Rates per 1,000 Population)

Race or Ethnicity	2012-2014 Number	2012-2014 Rate	2015-2017 Number	2015-2017 Rate
Black	159	.13	251	.20
American Indian	21	.10	51	.23
White	1441	.09	1961	.13
Hispanic	70	.06	125	.11
Asian	8	.02	4	.01

Source: Wisconsin Death Certificates, DHS.

Access to Substance Use Services

The below table 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. 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.

Substance Use Service Adult Participants Served, Wisconsin, 2017[a]

Wisconsin Programs/Agencies Providing Substance Use Services	Adults Served (18+)
County Public System	30,617
Medicaid Fee-for-Service	27,825
Medicaid Managed Care	33,024
Unduplicated Subtotal	**70,267**

NOT FINAL

DRAFT

State Mental Health Institutions	264
Corrections	3,089
Commercial Insurers[b]	45,102
Total Service Participants Served (partially unduplicated)[c]	**118,722**

a - See Needs Assessment 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.

In the Prevalence of Needs section of this report, it was estimated that 8.5% of adults (379,888) have a substance use problem within a year in Wisconsin. Subtracting the 118,722 adults who received substance use services in 2017 from this figure, the number of individuals who did not receive services for their need was 261,166. This is a treatment gap of 69%.

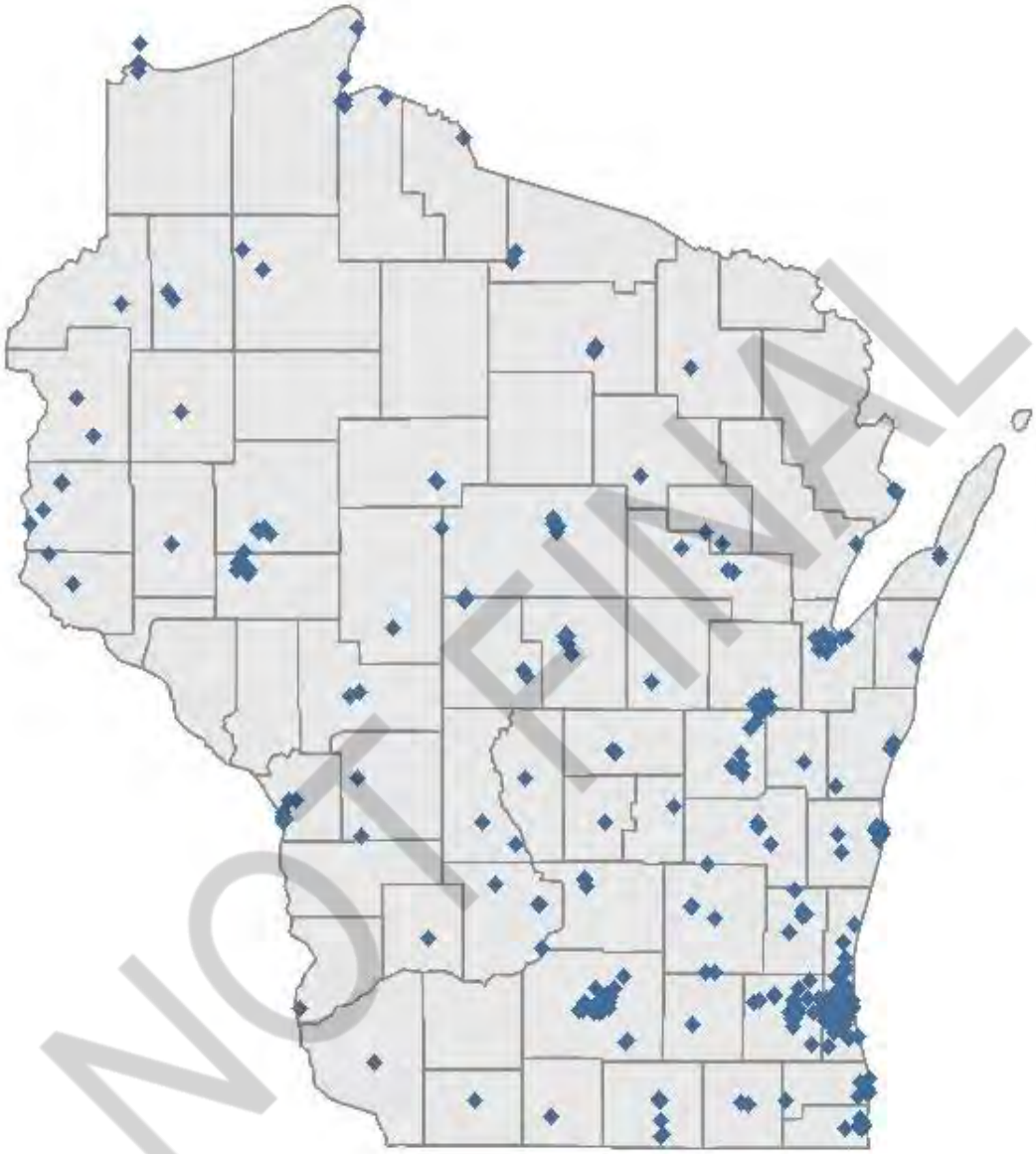
Substance Use Service Workforce/Capacity

The below map shows the location of substance use services providers certified by the DHS Division of Quality Assurance. These providers perform inpatient, medically monitored treatment services, emergency outpatient, day treatment, and other types of services.

NOT FINAL

DRAFT

State Certified Substance Use Providers



NOT FINAL

Source: Division of Quality Assurance, DHS

Opioid Treatment Programs

There are 22 opioid treatment programs in Wisconsin. These programs are specially licensed centers that provide Food and Drug Administration-approved medications combined with counseling and other support services.

DRAFT

Buprenorphine prescribers

The use of medications such as naltrexone, buprenorphine, and methadone to supplement psychosocial addiction treatment is an evidence-based approach to care. As of March 2019, there were approximately 880 federally approved prescribers of buprenorphine in Wisconsin. They are approved for varying caseloads of 30, 100, and 275 patients each. Even with this capacity, the availability of slots and prescribers for this medication continues to impede efforts to provide or expand opioid treatment in many areas of Wisconsin. At that time, fifteen (21 percent) of Wisconsin's 72 counties did not have access to a buprenorphine prescriber.

Unmet Service Needs and System Gaps for SABG Priority Populations

In the Prevalence section of the 2019 MHBG/SABG Needs Assessment report, the Wisconsin Dept. of Health Services (DHS) estimated that during 2017, 261,166 of 379,888 adults statewide (or 69%) who had a substance use problem within the past year did not receive services for their problem. Among persons who did not receive substance use treatment and services were those falling within the SABG priority populations – pregnant women and women with dependent children, and persons who inject drugs.

Pregnant Women and Women with Dependent Children

In 2011-12, nearly 6% of pregnant women aged 15-44 reported illicit drug use during their pregnancies, according to SAMHSA. Estimates from the 2017 National Survey on Drug Use and Health (NSDUH) suggest that rates of SUD vary across different population groups. The NSDUH estimated that 16.6% of pregnant women nationally had a substance use disorder.

The Wisconsin Association for Perinatal Care, in its publication *Challenges in Perinatal Substance Abuse: Educational Strategies for Care Providers and Communities*, reported that substance use in the perinatal period is a problem that crosses all socio-economic levels**.** Early emphasis in perinatal care focused on the consequences of illicit drug use, alcohol, and tobacco during pregnancy. Since the 2000s, there has been a significant increase in the use of opioids during pregnancy. Between 2000 and 2009, for example, antepartum maternal opioid use increased from 1.19 to 5.63 per 1,000 hospital births per year. In addition, the incidence of neonatal abstinence syndrome diagnosed before newborn discharge increased from 1.20 to 3.39 per 1,000 hospital births per year.

The Wisconsin Maternal Mortality Review and Recommendations Report, published by DHS in April 2018, noted that 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 drug or alcohol use before, during, and after pregnancy. Increased availability of care and substance use treatment services is needed for women before, during, and after pregnancy, including substance use treatment services for women of reproductive age.

DHS has continued to receive anecdotal reports of instances where pregnant women who are in county jails have been taken off their medications or cannot access women-based treatment programs due to lack of program slots. In addition, as methamphetamine use disorders continue to rise throughout the state, particularly in the northwestern region, several counties report a significant increase in the number of out-of-home placements of children due to parent methamphetamine disorders.

NOT FINAL

DRAFT

People Who Inject Drugs

The CDC's 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes stated that in 2016, an estimated 48 million persons aged 12 years and older (or 18% of the total population), reported use of illicit drugs or misuse of prescription drugs in the past year. Reported prevalence of illicit drug use in the past year by drug type included: 0.4% for heroin, 1.9% for cocaine, 0.5% for methamphetamine. Reported prevalence of opioid misuse (heroin use or prescription pain reliever misuse) in the past year was 4.4%.

People who inject drugs (PWID) are at risk for hepatitis B virus (HBV) and hepatitis C virus (HCV) infection through the sharing of needles and any equipment used to prepare and inject drugs. The opioid misuse epidemic has substantially increased the transmission risk of blood-borne viruses, including hepatitis C virus and HIV, through injection drug use.

Since the early 2000s, Wisconsin has been experiencing a surge in opioid misuse and its related harmful consequences. 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 age-adjusted rate for mortality related to drugs increased from 10.9 in 2009 to 21.5 deaths per 100,000 population in 2017. Deaths involving heroin and prescription opioids also increased from 2006 to 2017. The number of total opioid-related deaths in Wisconsin during 2018 was 839.

The impacts of drug use, specifically focused on opioids, are also revealed through hospital data. Since 2005, the rate of opioid-related hospital discharges has increased steadily. The age-adjusted rate of opioid-related discharges has significantly increased from 252.7 in 2009 to 475.4 per 100,000 population in 2017; the age-adjusted rate of heroin-related hospital encounters increased from 5.2 in 2009 to 41.9 per 100,000 population in 2017 (WI Interactive Statistics on Health, 2019).

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. Also, the rate of past year opioid use disorder per 1,000 Wisconsin persons age 12 and over during 2015-16 was 7.40 per thousand. Of those persons, 6.98 per thousand did not receive treatment at a specialty facility.

In 2018, 70 of Wisconsin's 72 counties had ambulance runs where naloxone was administered. According to the DHS ambulance run data system, there were 3,791 ambulance runs in 2018 across Wisconsin where naloxone was administered. This is a slight decrease since 2015 (3,857 ambulance runs with naloxone administration). This may be due to the increasing availability of naloxone through community organizations.

In 2017, DHS reported that there were 3,408 persons in county-authorized services across the state who reported injecting as a route of administration for drug use. During 2018, 559 persons were served in Injection Drug Use Treatment projects administered by Milwaukee, Dane, Kenosha and Racine counties and Aids Resource Center of Wisconsin (ARCW). These projects received SABG funds. Furthermore, project staff from Injection Drug Use Prevention projects administered by Kenosha Co. and ARCW provided outreach and education activities through 72,518 contacts across the state.

NOT FINAL

DRAFT

Research has shown that the national increase in acute HCV infection is related to the national opioid epidemic and associated increases in injection drug use.

Tuberculosis

Wisconsin has minimized the number of persons who contract tuberculosis over the years. In 2018, the Wisconsin Tuberculosis Program within DHS reported 49 cases of TB across the state. From July 2018 – June 2019, there were 4,281 cases of latent TB infection reported into the WI Electronic Disease Surveillance System, although many of these cases were not confirmed. (Persons with latent TB infection do not have symptoms and cannot spread TB.) TB screenings and referrals are occurring in many settings across the state, including county behavioral health screenings and assessments of persons with substance use disorder issues. The Wisconsin TB Program does not receive reports on county and other behavioral health screenings and assessments, so it is unable to surveil the number of screenings and referrals.

Primary Prevention Needs and Gaps

The last completed Wisconsin Epidemiological Profile (2016)[3] established several priorities based on Wisconsin's identified needs and areas of focus. Those areas include: (1) Underage drinking (ages 12-20); (2) adult binge drinking (ages 18-34); (3) drinking among pregnant women; (4) drinking and driving (especially among people ages 16-34); and (5) opioid use for nonmedical purposes (especially among people ages 20-54). Since that Profile, other needs and gaps have been identified by the Regional Prevention Coalitions and county prevention specialists across the state. These needs include strategies for collecting assessing vaping rates and providing education on vaping harms, and developing a statewide strategic plan for alcohol use prevention, particularly among youth.

Key Gaps and Barriers Identified in the Behavioral Health Gaps Report

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

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

[3] Wisconsin Department of Health Services, Division of Care and Treatment Services and Division of Public Health. Wisconsin Epidemiological Profile on Alcohol and Other Drugs, 2016 (P-4571-16). Prepared by the Division of Care and Treatment Services, Division of Public Health, and the University of Wisconsin Population Health Institute. November 2016.

NOT FINAL

DRAFT

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

For both MH and SUD services, cultural barriers were identified as most frequent in outpatient services. Stigma in the form of worldviews that imbue shame onto behavioral health needs and contexts that discriminate against consumers that have sought behavioral health services were noted as two notable barriers to behavioral health services across the arrays. It was also highlighted that stigma regarding both MH and SUD needs may be particularly deep rooted in rural areas.

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

Mental Health Gaps and Barriers Identified in the Behavioral Health Gaps Report

In the interviews, psychiatrists and psychiatric prescribers were the most common workforce gap identified in mental health. Inpatient and residential mental health services were identified as most challenging to access because of both insurance limitations/cost and physical distance to said facilities in the current state of the system.

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

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

Almost half of the respondents to the survey highlighted the need to increase access to mental health services as a priority area including suggestions to develop a regional model such as the hub and spoke model utilized in SUD. Close to one-third of respondents highlighted a need to both develop the

NOT FINAL

DRAFT

workforce and focus on funding in order to reduce operating costs and reduce turnover for individual behavioral health organizations. One fifth felt that the service array needed to be altered by increasing case management services, offering respite to families, addressing the root causes of MH challenges via improving the social determinants of health such as safe and affordable housing and childcare, and by improving crisis services with a reduced reliance upon police as a resource.

Substance Use Disorder Gaps and Barriers Identified in the Behavioral Health Gaps Report

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

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

NOT FINAL

Planning Tables

DRAFT

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Persons Who Inject Drugs

Priority Type: SAP, SAT

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 intravenous drug use-related deaths and 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 intravenous 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) 2020, there were 2,758 persons in county-authorized services who reported injecting as a route of administration for drug 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 2 percent over the baseline level during CY 2021.

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 2 percent over the baseline level during CY 2022.

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 consumers served to the PPS SUD data system. The federal SABG 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 problem and route of administration), services received (such as outpatient vs. inpatient), and the outcomes of treatment (such as treatment completion, substance problem at discharge, support group attendance, and number of arrests at discharge). The specific data here is the count of persons served that year that have needle or injection as the route of administration for their primary, secondary, or tertiary substance problem.

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) Note that Indicator #1's measure covers calendar years because the PPS SUD Module collects county-based treatment data on a calendar year basis. CY 2017 data is the most current data available for establishing the baseline.

NOT FINAL

Priority #: 2

Priority Area: Youth Access to Tobacco Products

Priority Type: SAP

Population(s): PP, Other

DRAFT

Goal of the priority area:

Reduce youth tobacco use.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The unweighted RVR for CY 2019 was 6.0%, with a weighted rate of at 5.5%. (Note 2019 is used as a baseline as a sample was not conducted in 2020).

First-year target/outcome measurement: The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 6.0 percent during CY 2021.

Second-year target/outcome measurement: The rate of successful tobacco purchases by youth (based on unweighted data) will be less than 6.0 percent during CY 2022.

Data Source:

The Synar compliance check effort is coordinated by the Department of Health Services, DPH'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. Another factor that could impact this priority is the potential for the annual purchase sampling to be disrupted due to the pandemic.

NOT FINAL

Priority #: 3

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAP, SAT

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 programming and services serving substance-using 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 10% of the SABG 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 treatment for substance-using pregnant women and women with dependent children.

Baseline Measurement: During SFY 2020 12 counties, tribes, and community providers received training and technical assistance and began implementing evidence-based practices and strategies targeting pregnant women and women with dependent children.

First-year target/outcome measurement: During SFY 2021, a minimum of five additional counties, tribes, and community providers will receive training and technical assistance and begin implementing evidence-based practices and strategies targeting pregnant women and women with dependent children.

Second-year target/outcome measurement: During SFY 2022, a minimum of five additional counties, tribes, and community providers will receive training and technical assistance and begin implementing evidence-based practices and strategies targeting 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:

Priority #: 4

Priority Area: Primary Prevention Services

Priority Type: SAP

Population(s): Other (Individuals in need of primary substance use disorder prevention services)

Goal of the priority area:

Prevent occurrences of substance use disorders among at-risk populations through the use of SABG funds for primary prevention services and activities.

Strategies to attain the goal:

(1) Require counties to spend at least 20 percent of their SABG community aids awards on 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 SABG fund allocation on primary prevention services, training, and technical assistance.

Baseline Measurement: During SFY 2020, Wisconsin spent 23 percent of its SABG expenditures on primary prevention services, training, and technical assistance.

First-year target/outcome measurement: During SFY 2022, Wisconsin will spend at least 20 percent of its SABG expenditures on primary prevention services, training, and technical assistance.

Second-year target/outcome measurement: During SFY 2023, Wisconsin will spend at least 20 percent of its SABG expenditures on primary prevention services, training, and technical assistance.

Data Source:

Department of Health Services, Bureau of Fiscal Services (BFS) records of SABG expenditures and the Division of Care and Treatment

DRAFT
NOT FINAL

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:

Priority #: 5

Priority Area: Reduce Adult and Youth Binge Drinking

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder, Individuals with Substance Use Disorder who engage in high risk drinking)

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 and strategies that limit youth access to alcohol. (4) Disseminate information, education, and messaging via the newly developed 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 5 or more beverages during an occasion of drinking) within the past 30 days.

Baseline Measurement: In CY 2019, 21.9 percent of adults in Wisconsin reported binge drinking within the past 30 days. (95% confidence interval range is 20.3-23.6 percent). Note: CY 2020 data is not yet available to use for the baseline.

First-year target/outcome measurement: During CY 2021, the percentage of adults who report binge drinking in the past 30 days will not exceed 21.6 percent.

Second-year target/outcome measurement: During CY 2022, the percentage of adults who report binge drinking in the past 30 days will not exceed 21.4 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:

Note that Indicator #1's measure covers calendar years because the annual binge drinking rate data available for adults and youth across Wisconsin is measured by calendar year.

Indicator #: 2

Indicator: The percent of youth ages 12-17 who report binge drinking (consuming 5 or more beverages during an occasion of drinking) within the past 30 days.

Baseline Measurement: In CY 2019, 5.57 percent of youth ages 12-17 reported binge drinking within the past 30 days. (Note: CY 2020 data is not yet available to use for the baseline.)

DRAFT
NOT FINAL

First-year target/outcome measurement: During CY 2021, the percent of youth ages 12-17 who report binge drinking will not exceed 5.4 percent.

Second-year target/outcome measurement: During CY 2022, the percent of youth ages 12-17 who report binge drinking will not exceed 5.2 percent.

DRAFT

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 of youth use of alcohol, including binge drinking.

Data issues/caveats that affect outcome measures:

Note that Indicator #2's measure covers calendar years because the annual binge drinking rate data available for adults and youth across Wisconsin is measured by calendar year.

Priority #: 6

Priority Area: Opioid Misuse and Abuse

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Reduce the number of opioid-related deaths in Wisconsin.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In CY 2020, there were 1,226 opioid-related deaths statewide.

First-year target/outcome measurement: During CY 2021, the number of opioid-related deaths statewide will not increase over the CY 2020 baseline of 1,226.

Second-year target/outcome measurement: During CY 2022, the number of opioid-related deaths statewide will decrease by at least 2 percent from the CY 2020 baseline of 1,226.

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 within the Division of Public Health, DHS.

Data issues/caveats that affect outcome measures:

Note that data utilized in this measure covers calendar years as the annual number of opioid-related deaths across Wisconsin is measured by calendar year.

Indicator #: 2

NOT FINAL

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

Baseline Measurement: During CY 2020, 4,186 persons with an opioid-related substance problem received county-authorized services.

First-year target/outcome measurement: During CY 2021, the number of persons receiving county-authorized services with an opioid -related substance problem will increase by at least 5 percent over the 2020 baseline level.

Second-year target/outcome measurement: During CY 2022, the number of persons receiving county-authorized services with an opioid -related substance problem will increase by at least 5 percent over the Year 1 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 consumers served to the PPS SUD data system. The federal SABG 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 problem and route of administration), services received (such as outpatient vs. inpatient), and the outcomes of treatment (such as treatment completion, substance problem 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 an opioid problem as their primary, secondary, or tertiary substance problem.

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. Note that Indicator #2's measure covers calendar years because the PPS SUD Module collects county-based treatment data on a calendar year basis.

Priority #: 7

Priority Area: Stimulant Use Disorder

Priority Type: SAP, SAT

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 addiction 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 problem who received county-authorized services annually.

Baseline Measurement: During CY 2020, 2,145 persons with a methamphetamine-related substance problem received county-authorized services.

First-year target/outcome measurement: During CY 2021, the number of persons with a methamphetamine-related substance problem receiving county-authorized services will increase by at least 5 percent over the baseline level.

Second-year target/outcome measurement: During CY 2022, the number of persons with a methamphetamine-related substance problem receiving county-authorized services will increase by at least 5 percent over the Year 1 level.

Data Source:

DRAFT
NOT FINAL

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 consumers served to the PPS SUD data system. The federal SABG 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 problem and route of administration), services received (such as outpatient vs. inpatient), and the outcomes of treatment (such as treatment completion, substance problem 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 a methamphetamine problem as their primary, secondary, or tertiary substance problem.

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.
(2) Indicator #1's measure covers calendar years because the PPS SUD Module collects county-based treatment and services data on a calendar year basis.

Priority #: 8

Priority Area: Culturally-appropriate and Comprehensive Services for Underserved Populations

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, Other (LGBTQ, Rural, Persons with Disablities, Homeless, Underserved Racial and Ethnic Minorities, Native American)

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 population groups. (3) Incorporate National Standards for 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 appropriate substance use treatment services. (4) DCTS will design a workplan to add fields within the current PPS data system, enabling providers to identify consumers as belonging to particular underserved population categories, allowing staff and policymakers to better track how substance use disorder services meet the needs of underserved populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of training, technical assistance, and consultation sessions or modules that are provided to service providers and underserved population communities that focus on increasing access to culturally-appropriate services.

Baseline Measurement: In SFY 2020, a total of 12 training, technical support, or consulting sessions/modules were provided to underserved population communities or service providers who target underserved populations.

First-year target/outcome measurement: During SFY 2022, a minimum of 14 training, technical support, or consulting sessions/modules will be provided to underserved population communities or service providers who target underserved populations.

Second-year target/outcome measurement: During SFY 2023, a minimum of 16 training, technical support, or consulting sessions/modules will be provided to underserved population communities or service providers who target underserved populations.

Data Source:

DHS and DCTS staff records, and training and technical assistance reports; county, tribal, and provider records.

Description of Data:

Number of training, technical support and consulting sessions provided that specifically target special population sub-groups,

DRAFT
NOT FINAL

communities, or service providers that serve persons of special populations.

Data issues/caveats that affect outcome measures:

DRAFT

Indicator #: 2

Indicator: Implementation of Culturally and Linguistically Appropriate Services (CLAS) in sub-granting proce

Baseline Measurement: As of September 2021, the Bureau of Prevention Treatment and Recovery (BPTR) as developed a plan for implementation of CLAS standards via the BPTR granting process.

First-year target/outcome measurement: As of October 2022, the BPTR will have implemented the first phase CLAS implementation, each grantee will be required to identify a CLAS lead for their agency.

Second-year target/outcome measurement: As of October 2023, 60% of BPTR grantees will have completed a CLAS plan for the implementation of CLAS standards.

Data Source:

BPTR contract records.

Description of Data:

Documentation of the roll-out of grant requirements and completed CLAS plans received by the BPTR.

Data issues/caveats that affect outcome measures:

NOT FINAL

Priority #: 9

Priority Area: Evidence-Based Practices in Mental Health and Substance Use Disorder Services

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, PWID

Goal of the priority area:

Expand the use of Evidence-Based Practices in the Mental Health and Substance Use Disorder service systems.

Strategies to attain the goal:

Provide training and technical assistance to counties, tribes, and other service providers on implementing Medication Assisted Treatment (MAT), and evidence-based primary prevention programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of DATA-waived, federally-approved buprenorphine prescribers in Wisconsin.

Baseline Measurement: As of June 2021, there were 1605 DATA-waived, federally-approved buprenorphine prescribers across Wisconsin.

First-year target/outcome measurement: By September 2022, the number of DATA-waived buprenorphine prescribers in Wisconsin will increase by at least 2 percent from the baseline target.

Second-year target/outcome measurement: By September 2023, the number of DATA-waived buprenorphine prescribers in Wisconsin will increase by at least 2 percent from the Year 1 target.

Data Source:

SAMHSA, Division of Pharmacologic Therapies, through a special request made by the Wisconsin State Opioid Treatment Authority.

Description of Data:

The unduplicated count of individuals who are Wisconsin buprenorphine prescribers and who fall within one of three lists of DATA-waived prescribers: 1) All approved prescribers; 2) Agencies that have prescribers; and 3) Approved prescribers who permit their name to

be listed in a public directory maintained by SAMHSA.

Data issues/caveats that affect outcome measures:

DRAFT

Priority #: 10

Priority Area: Behavioral Health Services in the Criminal Justice System

Priority Type: SAT

Population(s):

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 service 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). 3) Expand the number of persons residing in correctional institutions or returning into the community who receive SUD treatment and support in programs held in juvenile corrections, correctional institution for females, and adult community corrections. 4) The OARS (Opening Avenues to Reentry Success) Program will continue to implement various evidence-based practices, including Motivational Interviewing and Trauma Informed Care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of people who participated in a Treatment Alternative Program (TAP).

Baseline Measurement: During CY 2019, 205 persons participated in a TAP.

First-year target/outcome measurement: During CY 2021 the number of persons participating in TAP will increase of 5 percent over the baseline number.

Second-year target/outcome measurement: During CY 2022 the number of persons participating in TAP will increase of 5 percent over the Year 1 number of people participating.

Data Source:

TAP contact 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 #1's measure covers calendar years because the TAP contracts are set up as calendar year programs, 2019 is the most current baseline metric, however we anticipate being able to utilize the 2020 data as a baseline once that data is available.

NOT FINAL

Priority #: 11

Priority Area: Certified Peer Specialists

Priority Type: SAT, MHS

Population(s): SMI, SED, ESMI, Other

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.

DRAFT

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Certified Peer Specialists in Wisconsin.

Baseline Measurement: As of August 2021 there were 1198 Certified Peer Specialists in Wisconsin.

First-year target/outcome measurement: As of Sept. 2022, an additional 40 people, above baseline, will have become Certified Peer Specialists.

Second-year target/outcome measurement: As of Sept. 2023, 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 2021 there were 54 Certified Parent Peer Specialists in Wisconsin.

First-year target/outcome measurement: As of Sept. 2022, an additional 10 people, above baseline, will have become Certified Parent Peer Specialists.

Second-year target/outcome measurement: As of Sept. 2023, 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:

NOT FINAL

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 FY2020, 173 youth and young adults received CSC model services.

First-year target/outcome measurement: In FY2022, an additional 15 youth and young adults will receive CSC model services above the baseline number served.

Second-year target/outcome measurement: In FY2023, 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 FY2020 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 FY2021 numbers are collected.

Priority #: 13

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: 39.5% of CST youth participants complete their services with “major or moderate” improvement at discharge (2020).

First-year target/outcome measurement: 41% of CST youth participants will complete their services with “major or moderate” improvement at discharge (2021).

Second-year target/outcome measurement: 42% of CST youth participants will complete their services with “major or moderate” improvement at discharge (2022).

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

DRAFT
NOT FINAL

(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:

DRAFT

Priority #: 14

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 2021.

First-year target/outcome measurement: Four new behavioral health organizations will complete the Wisconsin Zero Suicide Training in Federal Fiscal Year 2022.

Second-year target/outcome measurement: Four new behavioral health organizations will complete the Wisconsin Zero Suicide Training in Federal Fiscal Year 2023.

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:

During the COVID-19 pandemic, fewer agencies had applied to participate in the Wisconsin Zero Suicide Training than prior years. Depending on the progress of the COVID-19 pandemic, fewer agencies may apply to participate, which could impact the ability to reach the targets for 2022 and 2023.

NOT FINAL

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

DRAFT

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	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)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$20,222,238.00		$380,000.00	$19,000,000.00	$20,600,000.00	$0.00	$0.00		$19,390,591.00	$8,781,917.00
a. Pregnant Women and Women with Dependent Children[c]	$5,365,794.00		$0.00	$0.00	$600,000.00	$0.00	$0.00		$3,671,150.00	$1,227,500.00
b. All Other	$14,856,444.00		$380,000.00	$19,000,000.00	$20,000,000.00	$0.00	$0.00		$15,719,441.00	$7,554,417.00
2. Primary Prevention[d]	$6,828,332.00		$0.00	$3,600,000.00	$700,000.00	$0.00	$0.00		$6,102,300.00	$2,205,000.00
a. Substance Abuse Primary Prevention	$6,828,332.00		$0.00	$3,600,000.00	$700,000.00	$0.00	$0.00		$6,102,300.00	$2,205,000.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
5. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$150,000.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$21,376.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$27,200,570.00**	**$0.00**	**$380,000.00**	**$22,600,000.00**	**$21,300,000.00**	**$0.00**	**$0.00**	**$0.00**	**$25,492,891.00**	**$11,008,293.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] 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" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

DRAFT

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	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)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$1,400,000.00						$1,426,000.00		$2,500,000.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$67,800,000.00		$47,595,822.00					
7. Other 24-Hour Care					$2,000,000.00					
8. Ambulatory/Community Non-24 Hour Care		$8,908,047.00	$459,500,000.00	$1,326,550.00	$134,093,888.00			$11,378,388.00		$5,465,019.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$100,000.00		$6,411.00				$20,000.00		$34,981.00
10. Crisis Services (5 percent set-aside)[g]		$2,000,000.00						$1,435,463.00		$16,630,652.00
11. Total	**$0.00**	**$12,408,047.00**	**$527,300,000.00**	**$1,332,961.00**	**$183,689,710.00**	**$0.00**	**$0.00**	**$14,259,851.00**	**$0.00**	**$24,630,652.00**

[a] 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" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] 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 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, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	10,789	182
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	173,556	3,908
4. Persons who inject drugs	37,812	2,800
5. Persons experiencing homelessness	1,567	1,187

NOT FINAL

Please provide an explanation for any data cells for which the state does not have a data source.
Women with dependent children: Wisconsin does not have a system in place to measure the number in treatment or in need of treatment currently.
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$20,222,238.00	$19,390,591.00	$9,281,917.00
2 . Primary Substance Use Disorder Prevention	$6,828,332.00	$6,102,300.00	$1,705,000.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$150,000.00	$0.00	$21,376.00
6. Total	**$27,200,570.00**	**$25,492,891.00**	**$11,008,293.00**

NOT FINAL

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]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" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]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 Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance 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 SABG 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 SABG funds with the flexibility to obligate and expend SABG 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 SABG 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 would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

DRAFT

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$247,714	$1,121,250	$766,506
	Selective	$54,986	$26,914	$3,664
	Indicated	$8,416	$4,119	$561
	Unspecified			
	Total	**$311,116**	**$1,152,283**	**$770,731**
2. Education	Universal	$2,541,876	$1,244,186	$419,376
	Selective	$564,237	$276,180	$37,597
	Indicated	$86,357	$42,270	$5,754
	Unspecified			
	Total	**$3,192,470**	**$1,562,636**	**$462,727**
3. Alternatives	Universal	$71,782	$35,135	$4,783
	Selective	$15,934	$7,800	$1,062
	Indicated	$2,439	$1,194	$163
	Unspecified			
	Total	**$90,155**	**$44,129**	**$6,008**
4. Problem Identification and Referral	Universal	$65,948	$32,280	$4,394
	Selective	$14,638	$7,165	$975
	Indicated	$2,240	$1,097	$149
	Unspecified			
	Total	**$82,826**	**$40,542**	**$5,518**
	Universal	$2,198,378	$2,836,052	$146,487

NOT FINAL

5. Community-Based Process	Selective	$487,989	$238,858	$782,517
	Indicated	$74,686	$36,557	$4,977
	Unspecified			
	Total	**$2,761,053**	**$3,111,467**	**$933,981**
6. Environmental	Universal	$190,740	$93,362	$12,710
	Selective	$42,340	$20,724	$2,821
	Indicated	$6,480	$3,172	$432
	Unspecified			
	Total	**$239,560**	**$117,258**	**$15,963**
7. Section 1926 Tobacco	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$120,349	$58,908	$8,019
	Selective	$26,715	$13,076	$1,780
	Indicated	$4,088	$2,001	$273
	Unspecified			
	Total	**$151,152**	**$73,985**	**$10,072**
Total Prevention Expenditures		**$6,828,332**	**$6,102,300**	**$2,205,000**
Total SABG Award[3]		**$27,200,570**	**$25,492,891**	**$11,008,293**
Planned Primary Prevention Percentage		**55.64 %**	**59.37 %**	**137.49 %**

[1]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

DRAFT
NOT FINAL

Footnotes:

DRAFT

NOT FINAL

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

DRAFT

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$2,065,979	$2,060,046	$517,665
Universal Indirect	$3,370,808	$3,361,127	$844,610
Selective	$1,206,839	$590,717	$830,416
Indicated	$184,706	$90,410	$12,309
Column Total	**$6,828,332**	**$6,102,300**	**$2,205,000**
Total SABG Award[3]	**$27,200,570**	**$25,492,891**	**$11,008,293**
Planned Primary Prevention Percentage	**25.10 %**	**23.94 %**	**20.03 %**

[1]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Tables

DRAFT

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

NOT FINAL

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

DRAFT

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	A. SABG Treatment	B. SABG Prevention	FFY 2022 C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems		$16,000.00			$1,000,000.00
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation		$216,293.00			
7. Training and Education	$113,986.00		$31,001.00	$115,888.00	
8. Total	**$113,986.00**	**$232,293.00**	**$31,001.00**	**$115,888.00**	**$1,000,000.00**

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

NOT FINAL

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]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" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Tables

DRAFT

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

MHBG Planning Period Start Date: 10/01/2021 MHBG Planning Period End Date: 09/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$35,000.00	$135,463.00		$35,000.00		
2. Infrastructure Support	$627,000.00	$600,000.00		$627,000.00	$600,000.00	
3. Partnerships, community outreach, and needs assessment	$693,800.00		$74,093.00	$693,800.00		$74,093.00
4. Planning Council Activities (MHBG required, SABG optional)	$20,000.00			$20,000.00		
5. Quality Assurance and Improvement	$1,332,000.00		$74,093.00	$1,332,000.00		$74,093.00
6. Research and Evaluation	$466,500.00		$49,396.00	$466,500.00		$49,396.00
7. Training and Education	$644,600.00	$1,311,000.00	$111,140.00	$644,600.00		$111,140.00
8. Total	**$3,818,900.00**	**$2,046,463.00**	**$308,722.00**	**$3,818,900.00**	**$600,000.00**	**$308,722.00**

[1] 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" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] 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 are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

DRAFT

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

NOT FINAL

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

DRAFT

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

NOT FINAL

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/million-hearts-initiative**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **https://www.samhsa.gov/find-help/disorders**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

DRAFT

NOT FINAL

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The State Mental Health Authority (SMHA)/ Single State Authority (SSA) for Substance Abuse Services, the Bureau of Prevention Treatment and Recovery (BPTR) is involved in many different coordinated care initiatives in the state. The HIV-AIDS Health Home was established in southeast Wisconsin under a 1945 State Plan Amendment (SPA). DHS is also piloting a foster care Medical Home called CARE 4 Kids in southeast Wisconsin. It is a combined initiative with the Department of Children and Families, Division of Medicaid Services, Birth to Three, Division of Care and Treatment Services (DCTS), and other entities. It coordinates physical and other forms of care for approximately 2,500 children in foster care in the region.

The psychosocial rehabilitation programs in Wisconsin are required to assess for the health care needs of their enrollees. Within the administrative rule for those psychosocial rehabilitation programs: Community Support Programs (CSP under DHS-63) and Comprehensive Community Support (CCS under DHS-36), there are standards to ensure that both mental health and addiction treatment needs, as well as, physical health is assessed along with a variety of other dimensions of life. It is part of the responsibility of the program to assure that mental health and addiction treatment and medical care is rendered. As a result of that assessment, treatment or recovery plans would include goals regarding wellness or addressing health risks as identified as a priority area by the individual and their health care team. The SMHA has gathered data from these programs as to the number of their consumers with key risks or medical conditions such as smoking, metabolic syndrome, high blood pressure, high cholesterol, obesity, diabetes, asthma, chronic obstructive pulmonary disease, and cardiovascular problems.

The Wisconsin DHS is also implementing a new initiative for collaborative planning and development of Health Homes for Substance Use Disorder (SUD) Treatment with a hub and spoke model. In these pilots, individuals with severe substance use disorders will receive specialized evidence-based SUD treatment and supports, including three forms of medication-assisted treatment, with integrated behavioral health and primary health care.

Health Home hubs will work with people who present with high intensity treatment needs and provide integrated care including the following services:
1) Comprehensive Care Management: identifying patients for treatment, conducting initial assessments, and formulating individual plans of care.
2) Care Coordination: implementing the plan of care through appropriate linkages, referrals, coordination, and follow up across treatment and human service settings and providers.
3) Health Promotion: empower the individual's healthy behaviors and self-management of health, mental health, and substance use disorder conditions.

4) Transitional Care and Follow-up: streamline movement of patients from one treatment setting to another, between levels of care, and between health, substance abuse, and mental health service providers.
5) Patient and Family Support: activities related to advocating on the individual's behalf and engaging the individual's natural support network.
6) Referral to Community and Social Supports: connect the person to medical, behavioral, educational, community, and social support services to support their ongoing recovery.

DRAFT

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

Comprehensive Community Services (CCS) is a recovery focused, integrated behavioral health program that provides community-based integrated services for individuals of all ages who need ongoing services for a mental illness and substance use disorder beyond outpatient care, but less than the intensive care provided in an inpatient setting. CCS provides a coordinated and comprehensive array of recovery services, treatment and psychosocial rehabilitation services that assist individuals to utilize professional, community, and natural supports to address their needs. Only counties and tribes can provide CCS in Wisconsin. CCS programs provide individualized services to each person and can receive cost-based Medicaid reimbursement on allowable costs. Medicaid reimbursement assisted in half of Wisconsin counties to provide CCS from 2005 to 2014. 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.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (•) Yes ( ) No

b) and Medicaid? (•) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

Wisconsin has a federally-facilitated marketplace. Wisconsin's Office of the Commissioner of Insurance is responsible to monitor Qualified Health Plans (QHP) and access to services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (•) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (•) Yes ( ) No

b) Health risks such as

ii) heart disease (•) Yes ( ) No

iii) hypertension (•) Yes ( ) No

iv) high cholesterol (•) Yes ( ) No

v) diabetes (•) Yes ( ) No

c) Recovery supports (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ( ) Yes (•) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ( ) Yes (•) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Lack of education of parity provisions at the local level.

10. 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: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], 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/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., 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 recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is 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[47]. 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[48]. 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, LGBTQ 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. 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.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

NOT FINAL

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] 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

DRAFT

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?

In accordance with the CLAS standards, DHS collects and publishes demographic data to monitor access and quality of care issues through the Program Participation System (PPS). Wisconsin continues to take steps to implement CLAS standards. The initial phase involved implementing CLAS standards within the BPTR structure through the training of staff in CLAS standards. Over the next two years the BPTR will be implementing CLAS standards through the Bureau's granting process. In year one grantees will be required to identify an agency contact who will serve as the agency's CLAS point of contact. By the end of year two grantees will be required to develop a CLAS plan.

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

3. Innovation in Purchasing Decisions - Requested

DRAFT

Narrative Question

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:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ 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.

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 of various mental and substance misuse prevention, 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 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 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 Evidence-Based Practices Resource Center 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 for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds 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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included 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."[53] SAMHSA and other federal partners, the HHS' 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 promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] 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)**[55] 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. 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.

NOT FINAL

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

DRAFT

[49] 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

[50] 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 Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

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, accountable care organization, 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: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

DRAFT

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.

NOT FINAL

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The Wisconsin Bureau of Prevention Treatment and Recovery (BPTR) contracts with Journey Mental Health Center, Milwaukee County, and a consortium of 9 counties in north-west Wisconsin to provide Coordinated Specialty Care Services (CSC) early intervention serves for people experiencing first episode psychosis. These programs are funded by the MHBG via the 10% set-aside. Wisconsin intends to fund additional organizations to provide CSC services beginning Fiscal Year 2022.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Wisconsin continues to fund CSC model services via the MHBG. In 2019 Wisconsin issued a funding opportunity for communities to implement systems improvements to better serve youth and young adults experiencing an ESMI.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ◉ Yes ○ No

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

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

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

   Wisconsin continues to utilize the Coordinated Specialty Care model for programs funded by the 10% set aside. Programs funded by the 10% may select which variant of CSC to utilize, but it must be a CSC model EBP to receive funding. Wisconsin has also used these funds to fund brief systems improvements to better serve youth and young adults experiencing an ESMI. In these efforts an organization was required to select a component or philosophy from the CSC model and incorporate that into the existing service array.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

   Wisconsin plans to continue funding CSC model programs in FFY 2022 and FFY 2023. It is anticipated that all current providers will continue to receive funding. New sites will be identified through a competitive procurement process.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

   Wisconsin collects and monitors data associated with the 10% set-aside funded CSC programs through two primary means. Enrollment and service outcome data is collected through Wisconsin's Program Participation System (PPS). All CSC providers are required to provide ongoing service data into this system. In addition, if a person who received services through a CSC program were to receive any additional behavioral health services through the public mental health system data regarding their services would be collected by the PPS. This ongoing data collection will allow Wisconsin to track long-term outcomes of those people who are served by the CSC programs. Additional data reporting, including financial data, is tracked through Wisconsin's contracting process with each agency that is receiving funding. Each agency also tracks their own data and monitors outcomes of their clients. Additional data will be reported and analyzed through fidelity measures.

10. Please list the diagnostic categories identified for your state's ESMI programs.

    Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Psychotic Disorder NOS.

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

    N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT
NOT FINAL

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

DRAFT

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.

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.

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 the practice of Person-Centered Planning when engaging consumers and their natural supports in services and planning. Each program requires that staff receive training in how to effectively partner with the consumer in every aspect of service delivery, ensuring that they practice a person-centered way of being. The inclusion of every consumer's voice is visible as evidenced by person-centered program documentation, especially assessments and individualized recovery and treatment plans. Program staff regularly receives training on how to effectively engage and utilize family and natural supports during the entire planning process, including service provision. Our statewide psychosocial rehabilitation program, Comprehensive Community Services (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. 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 require consumer and family involvement, especially in the assessment and recovery planning process. 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 specifically require Person-Centered Planning. Wisconsin has finalized a model for Person-Centered Planning that includes practice measures of fidelity. In addition, Wisconsin has been able to add a virtual PCP training on the Department website that is forward facing and allows any mental health or substance use agency to have their staff take the virtual training and receive a certificate of completion. This allows agencies to utilize the training for new hires and annual training for all staff and any practitioner take the training. By having a virtual first level training, frees state training staff up to provide more in-depth training and technical training to those who want it. In addition, Wisconsin utilizes its annual Mental Health and Substance Use Recovery Conference and bi-weekly educational teleconference to promote the use of recovery-oriented, Person-Centered Planning and the positive outcomes associated with it.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

DRAFT

Narrative Question

SAMHSA has placed 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 SABG 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 SABG 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 SABG 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 SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder 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 SABG. 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.

NOT FINAL

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

Oversight of Contracts & Grants

One of the Division of Care & Treatment Services' (DCTS') major strengths is our thorough contract procurement and management activities, as we oversee the implementation of the SABG and MHBG programs. Within DCTS, the Contract Administration Workgroup and its several sub-groups meet regularly to review and suggest refinements and improvements to various facets and functions within the contract management process.

Each contract and grant is assigned to a contracts administrator, who is responsible for ensuring compliance with federal and state laws and the contract/grant requirements, including both block grant programs. The primary purpose is to consistently implement a division-wide, standardized process for administering and overseeing the SABG and MHBG programs. The DCTS has also begun implementing new tools for contract administrators to monitor financial expenditures through tracking sheets to monitor collaboratively with their grantees.

Notifying providers of federal program requirements

Block grant funds are distributed to Wisconsin counties, tribal units, and providers via direct contracts or an appendix to the state/county base contract. These appendices describes the federal program requirements pertaining to primary prevention, treatment services for women expenditures, tuberculosis, HIV, the payment schedule, and restrictions on expenditures of SABG funds. The last section of the Appendix states: "Requirements herein stated and in the base contract apply to any sub-grants or grants. The contracting agency has primary responsibility to take constructive steps to ensure compliance of its subcontractors. The county must inform the sub-grantees of the federal award information set forth."

DRAFT

Similarly, the MHBG Appendix to the state/county contract (under CARS Profile #569) details definitions, client eligibility criteria, allowable programming and services, allowable and restricted uses of funding, target populations, reporting requirements, and statutory requirements that must be met with the use of MHBG funds. In both block grant programs, the DCTS administrator sends out an annual Numbered Memo that lists the various block grant requirements that counties and tribes must comply with when receiving and expending community aids funds.

For direct contracts using SABG and MHBG funds, the award documents include an attachment (Exhibit 3) that recites the text of the federal statutes and regulations – including the SABG and MHBG -- that apply to that specific contract. That text is incorporated by reference into the primary contract or written agreement that is fully executed by both parties. DCTS staff continue to update these Exhibit 3 documents to ensure any new or updated requirements are conveyed to grantees.

Monitoring Appropriate Use of Grant Funds

The DCTS employs standardized review and oversight practices at various stages of contracting to ensure that contract and grant recipient agencies are appropriately using SABG and MHBG funds.

Each contract includes a work plan that contains goals, objectives, and related activities to ensure that contracts comply with the purpose of the grant funds. Applicants must submit a budget on a standardized template that details how the funds will be spent and provides a justification for each expense. The contract administrator, a contracts specialist, budget analyst, and supervisor all review and approve the proposed budget to ensure that expenditures are allowable and reasonable under state and federal law. In the event that the applicant plans to sub-contract funds, the budget forms also include expenditure and justification information for each sub-contractor agency. Contract Administrators also complete an annual Risk Assessment for each grantee.

The majority of block grant claims and payments are managed and monitored via the Division of Enterprise Service's (DES) Community Aids Reporting System (CARS). The system records all expenditures from the county and non-county providers, calculates amounts due and adjustments back to the state, and also generates reports for providers and counties under contract with the state. In addition, several block grant claims and payments are issued through purchase orders at the DES. Contract vendors submit invoices, which are first reviewed for accuracy and reasonableness by the assigned contract administrator and approved by a supervisor.

DCTS' budget analyst provides quarterly projections of block grant award balances, the planned contract and operational expenditures for each block grant award, the contracts obligated, and contracts expended; these projections are provided to DCTS management. The budget analyst also confers regularly with the assigned DES accountant for SABG and MHBG grant funds to monitor expenditure patterns and ensure compliance with block grant requirements. Each month DCTS staff creates and shares a financial status update of all block grant-funded contracts to DCTS management and contract administrator, who use these updates to track whether contractor agencies are spending block grant funds in a timely manner, and to provide assistance to help agencies overcome obstacles and challenges.

Compliance reviews and performance reporting

DCTS contract managers provide regular oversight for their assigned contracts/grants. Contract managers follow a division-wide, standardized process for awarding and administering contracts/grants, including a standardized process for submitting performance reports. All direct contract block grant-funded programs are required to submit semi-annual performance reports to the contract administrator. All contracts and grants contain deliverables and detailed outcomes for contract administrators to periodically monitor the achievement of. DCTS requires contract managers and contract agencies to utilize SMART (Specific, Measurable, Achievable, Realistic, and Time-specific) objectives in all contracts as a tool for ensuring that programming complies with block grant requirements and that contracts are achieving desired outcomes and client behavioral improvements.

Also, contract administrators conduct annual on-site monitoring visits utilizing questionnaire check forms tailored for SABG and MHBG-funded programs. These visits include a review of:

- The semi-annual performance reports to monitor progress on goals and objectives;
- The original budget and any modifications;
- The most recent board of directors report, if applicable;
- How expenses are tracked;
- The DHS fiscal reporting system to monitor expenditures;
- How contractor agencies monitor their subgrantees/subcontractors;
- Follow-up on any audit issues;
- Any training and technical assistance needs.

NOT FINAL

In addition, SABG and MHBG grant funds are used to provide counties with community aids money specific to substance use disorders and mental health. All counties receive block grant funds per a formula to address substance use disorders and mental health issues. The counties submit annual MHBG and SABG report detailing expenditures so DCTS can ensure they are spending in accordance with the contract requirements. Also, DCTS conducts annual peer reviews of selected providers.

Encounter, utilization, and performance analysis reports are created to analyze block grant-funded agency programs using the division's Program Participation (PPS) data system. Counties and some other agencies receiving block grant funds are required to report data into PPS at quarterly intervals, though many in fact report data on a monthly basis. Agencies receiving SABG funds for primary prevention programming must report annually using the Substance Abuse Prevention Services Information System (SAP-SIS) data system. The report includes information on what primary prevention programs were implemented, the cost of those programs, and population served demographic information. In addition, some programs are required to submit data through other formats. The data from these systems are used to collect federally-required data, guide SSA/SMHA programming and funding decisions, and provide local agencies with information to guide their behavioral health programming and funding decisions. The DCTS is currently in the initial stages of planning for the design and implementation of a new data system to improve overall data collection through a modern, more robust platform.

Contract/grant awards for projects funded outside the state/county contract require an annual audit if the sub-contractor/grantee receives $100,000 or more in grant funds in total amount of annual funding provided by DHS (from any and all of its Divisions or subunits taken collectively). Those entities must submit single agency audit reports to DHS when the combined amount of federal funds received by an entity exceeds $750,000. The audits are reviewed by the DHS Office of the Inspector General (OIG), in collaboration with DCTS staff, to determine if there are any findings of significance related to the two block grants within specific contracts or grant awards. In such instances, the contract manager reviews the findings and, when necessary, works with the entity to develop corrective action plans. Under SABG-funded contracts/grants, the audit requirement is applicable to subcontractors and sub-grantees. The state/county contract, §5.01, requires counties to have a single audit pursuant to OMB Circular N. A-133.

Please indicate areas of technical assistance needed related to this section

None applicable.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT
NOT FINAL

DRAFT

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**[56] 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.

[56] **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?

Division Administrators 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 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.

2. What specific concerns were raised during the consultation session(s) noted above?

Specific concerns raised during the consultation and meetings above included: staff turnover in many tribal agencies; a lack of a community youth center; workforce shortage (not many people want to move up north), and lack of minority trainings for tribes and other underserved communities; licensure issues with Department of Safety and Professional Services (DSPS); lack of understanding about the Community Comprehensive Program (CCS); an increase in affected babies born with drug addiction; and a lack of communication about the Governor's Task Force on Opioid Abuse.

3. Does the state have any activities related to this section that you would like to highlight?

Activities related to tribal communities that we would like to highlight include the following:
Staff involved in the annual Mental Health and Substance Use Disorder Recovery Conference each fall have consistently outreached and recruited workshop presenters from the underserved communities, especially from tribes. In the past few conferences, there were fewer workshops conducted by tribal staff focusing on their culturally competent services to their community. The effort to outreach to tribal communities to conduct workshops at the DHS' Prevention Training Conference is slow due to a high turnover at tribal agencies. As a result, there were no specific tribal workshops from tribes at our annual conferences.

In the next fiscal year, DCTS staff will repeat a very successful Minority Leadership Institute that DHS provided in 2013. The Minority 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 minority communities (i.e., 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 minority communities. The second leadership training was held in 2021 and another leadership training will be held in 2022.

CCS State Coordinators continue to work with tribes to provide technical assistance for those that became CCS providers while developing interest in becoming CCS providers among other tribes. 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.

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.

With staff changes at DHS, we were not able to provide the needed Substance Abuse Prevention Training (SAPT) training as planned. However, DHS staff is working with new staff as needed and plan to provide ongoing technical assistance to tribal staff.

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

DHS staff continue to provide technical assistance to new tribal staff both at quarterly meetings and through individual phone calls to assist the new staff on how to fill out the DCTS Work Plan and Budget forms in order to monitor accountability and outcomes more efficiently. A monthly technical assistance meeting for tribal agencies is held to answer any program questions and provide any program updates to tribes in 2021. Significant staff time was spent working with tribal staff on how to fill out the new work plan and budget forms from DHS. Although a few tribal agencies are completing their work plans and budgets thoroughly and effectively, others still need more technical assistance.

Staff continues to provide technical assistance to tribal agencies and staff as identified and discussed. DHS continues to require tribal agencies to use DHS' work plan and budget forms in our contracting process. Due to the new hires, DHS staff anticipated having to provide much technical assistance. DCTS and Tribal Affairs Office staff continue to jointly provide both in-person and phone meetings to provide follow-up technical assistance after discussing changes in our contracting process during several statewide meetings. DHS staff provided support to assist tribal staff in filling out the DHS Work Plan and Budget forms. Initially, a few tribal agencies required a few extra days of phone and in-person meetings to understand the new forms. While there is still some need for ongoing technical assistance, we have witnessed great progress, especially increased understanding of performance measures that document greater outcomes produced from tribal agencies within our funded programs.

Specifically, state staff continue to encourage tribal staff to apply SMART objectives in completing their DHS work plans and budgets. DHS staff provided technical assistance by bringing appropriate staff to conduct training on SMART objectives and how to incorporate them into the work plan and budget. While a few tribal agencies already used SMART objectives in their work plans, the remaining agencies are gradually moving toward integrating SMART objectives into their work plans.

As tribal agencies learned about new initiatives at DHS and requested further information, DHS staff arranged for appropriate staff to present on the requested topic, whether it was Integrated Peer Support or CCS Program for tribal staff during the State Collaborative for Positive Change program meeting. Appropriate DHS staff continue to update tribal agencies on existing programs as trainings become available. TA is also provided directly to the tribes who are implementing the Coordinated Services Team (CST) Initiatives in Wisconsin.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT
NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SABG

DRAFT

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute 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 Process*** 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.

Please respond to the following items

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)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] 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)

- [x] Children (under age 12)
- [x] Youth (ages 12-17)
- [ ] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

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

NOT FINAL

- [x] Archival indicators (Please list)

* Alcohol Outlet Density
* Treatment Admissions
* School Alcohol/Drug related Suspensions & Expulsions
* Arrests
* Acts of Violence

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ○ Yes ◉ No

If yes, (please explain)

If no, (please explain) how SABG funds are allocated:

DRAFT
NOT FINAL

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute 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 Process*** 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 Building

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

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 disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

DHS, Division of Care & Treatment Services (DCTS) administers five regional prevention training and technical assistance centers to support capacity building activities for the Alliance of Wisconsin Youth Coalitions statewide.

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

If yes, please describe mechanism used

DRAFT
NOT FINAL

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute 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 Process*** 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.

Planning

1. Does your state have a strategic plan that addresses substance use disorder 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

SCAODA's 2018-22 Strategic Plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) 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 SABG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [x] Cultural competence component
- **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 SABG 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 SABG primary prevention funds? ( ) Yes (●) No

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

Note: The SSA staff gives approvals and guidance on EBPs and best practice strategies for providers and grantees to use.)

DRAFT
NOT FINAL

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute 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 Process*** 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.

Implementation

1. States distribute SABG 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 SABG primary prevention dollars in each 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; hot lines; 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 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 75.04 of the Wisconsin Administrative Code provides standards for community-based prevention substance use services. Specifically, DHS 75.04 (4) (a) (4) states:

'Problem identification and referral.' This strategy is to identify individuals who have demonstrated at-risk behavior, such as indulging in illegal or age-inappropriate use of tobacco or alcohol or indulging in the first use of illicit drugs, to

DRAFT
NOT FINAL

determine if their 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 are 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.

In addition, counties that receive annual SABG community aids awards must allocate at least 20 percent of those awards to primary prevention activities and strategies. Each year counties receive, as part of their contract awards, an appendix that identifies six primary prevention strategies typically funded with primary prevention set-aside funds.

e) Community-Based Processes:

Accessing services and funding; community team-building; multi-agency coordination and collaboration; systemic planning

f) Environmental:

Monitoring enforcement on availability of alcohol and substance use

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

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 SABG community aids grant award that is spent for prevention. Use of funds are reviewed for compliance with the various SABG block grant requirements as well as other federal and state requirements.

DRAFT
NOT FINAL

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute 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 Process*** 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 disorder 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 SABG 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 SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm
- **c)** ☐ Disapproval of use

DRAFT
NOT FINAL

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

DRAFT

NOT FINAL

Footnotes:

DRAFT

NOT FINAL

SCAODA Four-Year Strategic Plan: 2018-2022 (FINAL 10.1.18)

DRAFT

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

SCAODA Primary Goals and Objectives for 2018-22
1. Change Wisconsin's cultural norms to transform the state's Substance Use Disorder (SUD) problems into healthy behavioral outcomes. Objectives: (a) Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.
2. **Inform Wisconsin citizens on the negative fiscal, individual, and societal impacts of substance use disorders.** Objectives: (a) Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.
3. **Advocate for adequate funding, capacity, and infrastructure to implement effective outreach, prevention, treatment, and recovery services for all in need.** Objectives: (a) Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee. (b) Address the rising levels of SUD needs for the senior population. (c) Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards. (d) Continue supporting and advocating the use of SBIRT (Screening, Brief Intervention and Referral to Treatment) models throughout schools and communities. (e) Support and advocate adoption of emerging innovative and promising SUD programs and practices. (f) Increase the excise tax on fermented beverages to meet the average tax of all states, and increase the portion of excise tax revenue apportioned to SUD programs.
4. **Remedy historical, racial /ethnic, gender, and other bias in substance use disorder systems, policies, and practices.** Objectives: (a) Improve the effectiveness of addressing the SUD needs of underserved populations. (b) Expand focus beyond services targeting needs of cultural/ethnic population groups to include the needs of socio-economic groups and geographic areas. (c) Support research and identification of SUD-related social determinants of health. (d) Support and advocate adoption of emerging innovative and promising SUD programs and practices that are incorporated within the national CLAS standards.

NOT FINAL

DRAFT

Committee	Objective/Plan to address SCAODA Primary Goal	Goal & Objective
Diversity	Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.	2(a)
	Improve the effectiveness of addressing populations-specific SUD needs.	4(a)
	Expand focus beyond services targeting needs of cultural/ethnic population groups to include the needs of socio-economic groups and geographic areas.	4(b)
	Support research and identification of SUD-related social determinants of health.	4(c)
	Support and advocate adoption of merging innovative and promising SUD programs and practices that are incorporated within the national CLAS standards.	4(d)
Intervention and Treatment	Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee.	3(a)
	Address the rising levels of SUD needs for the senior population.	3(b)
	Support and advocate adoption of emerging innovative and promising SUD programs and practices.	3(e)
Planning & Funding	Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.	1(a)
	Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.	2(a)
	Increase focus and resources for youth and adolescent prevention and treatment programs, to include: (1) collegiate recovery and support resources; and (2) continue revitalizing the Children, Youth and Family Treatment Sub-Committee.	3(a)
	Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards.	3(c)
	Continue supporting and advocating the use of SBIRT (Screening, Brief Intervention and Referral to Treatment) models throughout schools and communities.	3(d)
	Increase the excise tax on fermented beverages to meet the avg. tax of all states; increase portion of excise tax revenue apportioned to SUD programs.	3(f)
Prevention	Reduce public stigma attached to seeking and obtaining SUD treatment and mental health services.	1(a)
	Enhance Council visibility as an SUD policy body and increase its level of advocacy to the Wisconsin Governor, Legislature and interested citizens.	2(a)
	Expand and train substance use disorder workforce capacity of prevention specialists and peer recovery specialists and coaches, including their capacity to understand and address the SUD needs of underserved populations with specific language and cultural issues as recommended in the Culturally and Linguistically Appropriate Services (CLAS) Standards.	3(c)
	Support and advocate adoption of emerging innovative and promising SUD programs and practices.	3(e)
	Improve the effectiveness of addressing the needs of underserved populations.	4(a)

NOT FINAL

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

DRAFT

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-occuring 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 is of the CSP is to reduce the need for repeated treatment and prolonged care in hospital settings. Each individual entering a CSP is assigned a case manager who develops a treatment plan with the individual, provides support and outreach, and assists in coordinating other services. 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

NOT FINAL

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.

DRAFT

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-occuring M/SUDs	(●) Yes ( ) No

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

3. Describe your state's case management services

As described above case management services are provided through Wisconsin's Psychosocial Rehabilitation programs CCS and CSP. Many county-based providers 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 Respites. 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 Respites 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. The three locations are open to adults statewide and are operated by non-profit organizations with support from the Department of Health Services. Wisconsin in 2020-2021 also implemented a Veterans Peer Run Respite in Milwaukee.

NOT FINAL

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.

DRAFT

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	4.88	
2.Children with SED	11.0	

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.

NOT FINAL

DRAFT

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 IDE	(●) Yes ( ) No
c)	Juvenile justice services	(●) Yes ( ) No
d)	Substance misuse preventiion 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 system	(●) Yes ( ) No

NOT FINAL

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.

DRAFT

Criterion 4

a. Describe your state's targeted services to rural population.

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. Wisconsin has implemented a dual diagnosis Certified Peer Specialist certification and a Parent Peer Specialist Certification. A Forensic Peer Specialist Certification is currently in development.

The use of TeleHealth in Wisconsin since 2007 has been increasing to help address the need for an array of MH/SA services. Psychiatry services in particular are lacking in many rural areas. Recent efforts to increase TeleHealth services in Wisconsin include a Child Psychiatry Consultation Program to provide support to physicians in two pilot areas, one rural and one urban. In this model the primary care physician provides direct patient care supported by a child psychiatric consultant. In addition, one of Wisconsin's state hospitals, the Mendota Mental Health Institute, provides direct community TeleHealth psychiatric services to patients both in rural and urban counties in need who could not find psychiatric services elsewhere.

b. Describe your state's targeted services to the homeless population.

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.

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.

c. Describe your state's targeted services to the older adult population.

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 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-

NOT FINAL

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.

DRAFT

NOT FINAL

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.

DRAFT

Criterion 5

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 has 53.3 FTE positions that are responsible for the following functions:

- Grants management and contract administration for Federal Block Grants and discretionary grants;
- Development and technical assistance for the Mental Health and Substance Abuse Administrative Rules and State Statutes;
- Contract administration for Community Mental Health & Substance Abuse 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 Abuse Services System.

Financial management is conducted by the BPTR in collaboration with the Bureau of Fiscal Services (BFS). The DHS uses the 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.

NOT FINAL

Footnotes:

DRAFT

NOT FINAL

10. Substance Use Disorder Treatment - Required SABG

DRAFT

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/social)	(•) 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:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	( ) Yes (•) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

NOT FINAL

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

DRAFT

NOT FINAL

DRAFT

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. Contract administrators maintain regular communications with their programs and grantees, providing technical assistance and supporting implementation of best practices to achieve program and performance goals. 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. Both 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 require them to address whether they are complying with the various SABG requirements, and what corrective steps were taken to meet compliance in instances where counties previously fell out of compliance. (All counties receive annual SABG-funded community aids awards DCTS is currently in the process of updating the system for waitlist reporting and ensuring the provision of interim services, to capture a broader scope of services across the state and improve timely reporting of treatment needs and access.

NOT FINAL

DRAFT

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, older adults)? — (•) Yes ( ) No

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

Within DCTS, the staff designated as the State Opioid Authority, as well as the SABG Planner, regularly receive wait lists and notification of 90% 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 SABG requirements, and what corrective steps were taken to meet compliance in instances where counties previously fell out of compliance. (All counties receive annual SABG-funded community aids awards.) In addition to ensuring that processes are in place for reporting wait lists and capacity, and that these requirements are communicated in contracts, DCTS also sends out regular communications reminding providers of waitlist reporting requirements and procedures.

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.

DCTS receives annual reports from counties that require them to address whether they are complying with the various SABG requirements, including tuberculosis, and what corrective steps were taken to meet compliance in instances where counties previously fell out of compliance. (All counties receive annual SABG-funded community aids awards.) In addition, DCTS confers and obtains compliance reports from the Division of Quality Assurance (DQA), which monitors certified substance use service agencies across the state to ensure compliance with tuberculosis and other communicable disease screening, information, and referral requirements. Citations are issued to those agencies found in violation of those requirements. Furthermore, DCTS collaborates with the DHS' Division of Public Health regarding the monitoring and testing of persons for tuberculosis.

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 the service delivery? — ( ) Yes (•) No

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

NOT FINAL

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

DRAFT

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 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 SABG funds to support elements of a Syringe Services Program?	○ Yes	◉ No

If yes, plese provide a brief description of the elements and the arrangement

NOT FINAL

DRAFT

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 memebers, 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)** MAT — (•) 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

NOT FINAL

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (•) Yes ( ) No

Patient Records

DRAFT

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.

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

5-6 reviews per 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)

NOT FINAL

DRAFT

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

NOT FINAL

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.

http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75/01 (Chapter DHS 75 of the Wisconsin Administrative Code, "Community Substance Abuse Service Standards")

https://docs.legis.wisconsin.gov/code/chr/all/cr_20_047

DRAFT

NOT FINAL

Footnotes:

DRAFT

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

DRAFT

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 2020-FFY 2021? ○ Yes ◉ No

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

12. Trauma - Requested

DRAFT

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. 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 have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these 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 doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, 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. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 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.*
58 *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 guide 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 have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

Wisconsin is emphasizing trauma-informed care at many levels. DCTS is a leader in promoting trauma-informed care for adults and has a contracted employee, Trauma-Informed Care (TIC) Coordinator that has trained and provided technical assistance for over 10 years. The TIC Coordinator allows the Division to provide statewide, consistent evidence-based training. In 2020 during the COVID -19 pandemic, the coordinator held 23 virtual training events and trained 2,141 people and held seven specific technical assistance events. Not only does DCTS provide training externally, but internally as well. DCTS has provided technical assistance to the TIC implementation at Sand Ridge Secure Treatment Center in assisting that group to find ways to implement TIC practices and culture change within SRSTC.

NOT FINAL

Presently, our attention has turned to the state's substance use disorder provider community and the need to ramp up trauma informed care education and technical assistance for those providers as the opioid epidemic has brought intense pressure on that system. DCTS is presently working with two organizations/consortia that have expressed interest in creating a trauma-informed communities.

DCTS is partnering with the Division of Public Health in developing a TIC training for Emergency Medical Services workers as part of a CDC grant. This work is now part of the Resilient Wisconsin initiative. DCTS and DPH are providing the TIC training for EMS workers and showing how TIC specifically relates to the opioid crisis in several regions in Wisconsin. A professional video training entitled: "Resilient Wisconsin First Responder Training" was created and is currently being distributed throughout Wisconsin to all facets of the public safety community. Through this work the intention is to eventually create a training package delivered by first responders, for first responders. In addition to DCTS, many varied department state staff and individuals, who are trained as ACE Master Trainers, continue to train counties and providers on Adverse Childhood Experiences (ACEs). The Governor's Office of Children's Mental Health champions trauma-informed care among all state departments and continues to bring stakeholders together, including peers; to engage, educate, and participate in a collective impact project that has its roots in TIC.

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

At this time, no technical assistance is needed for this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT

NOT FINAL

DRAFT

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? — (•) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? — (•) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? — (•) Yes ( ) No

4. 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

5. 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 Coordinating Council to assist with diversion for individuals with substance abuse and mental health needs who are involved with or have had contact with the criminal justice system.

The SSA and SMHA are both involved as a partner with the WI Department of Justice's (DOJ's) Evidence Based Decision Making Initiative to work on diversion and use of evidence based practices (EBPs).

The SSA & SMHA have a collaborative partnership with 84 local Treatment Courts statewide (with another 5-7 counties and tribes in the process of developing programs), along with DOJ and the WI Department of Corrections (DOC) by providing clinical consultation and support for use and incorporation of the ASAM placement criteria and EBPs within the State of Wisconsin Treatment Court Standards. Also, this collaborative partnership provides or supports technical assistance on the use of EBPs in the full continuum of services for substance use treatment & recovery services.

The SSA has supported the ongoing training for a trauma informed response to the criminal justice client to support evidence

NOT FINAL

based practices and decrease risk for traumatization with our partners in DOJ, DOC, peer support specialists and community providers who serve this population.

The SSA has consulted with DOC regarding implementation of EBPs such as ASAM and standardized substance use disorders assessments and treatment services for individuals re-entering the community setting from a DOC institution, and use of medication-assisted treatment (MAT) and coordination with community providers for continuum of care for substance abuse services.

In addition, SSA and SMHA staff the Criminal Justice Committee within the WI Council on Mental Health. The Committee has supported and collaborated with DOC, DOJ, peer specialists, and other agencies in supporting substance use disorder services and assistance for persons involved in the criminal justice system and those reentering communities. The Committee also 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 BadgerCare, 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 AODA services for persons on reentry or at halfway houses as their return into their communities; (3) juvenile justice gang diversion programming that features AODA prevention and education, and substance use disorder treatment; (4) county treatment alternative programs that provide dispositional, treatment-based alternatives to incarceration for persons going through the criminal court process; (5) the approximately 90 problem-solving courts operating across the state, including OWI, adult drug, veteran, tribal healing to wellness, and mental health courts; (6) the state-funded prison reintegration program that assists Milwaukee County residents in transitioning back home and meeting their substance use disorder and other needs; and (7) the 13 Medication Assisted Treatment (MAT) in the Jail state funded programs in which individuals with opiate use receive Vivitrol injections prior to leaving the jail and subsequent treatment with a community substance use provider and case management services to assist applying for Medicaid and (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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT
NOT FINAL

DRAFT

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

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 use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

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.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

NOT FINAL

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

In 2019 Wisconsin opened the first 24/7 Opioid Treatment Program in the Midwest. That clinic partnered with the Milwaukee County Behavioral Health Division in order to provide access to MAT and counseling for those that are under/uninsured using SABG funds. Since its inception it has served over 2000 citizens that reside in that county. In the last 5 years WI has averaged opening one new OTP a year and this year will be initiating a health home model similar to the hub and spoke model where all three forms of FDA-approved medication for the treatment of Opioid Use Disorder will be offered.

DHS continues to partner with the Wisconsin Society of Addiction Medicine to provide ongoing trainings for prescribers interested in receiving their waiver to prescribe buprenorphine products. These trainings have been provided in-person and during the pandemic they were offered via a virtual platform. WI has continued to see an increase in prescribers across the state. Since initiating the trainings in 2018 we have seen over a 60% increase in the number of prescribers in our state.

Other programs currently within the State include: the Strategic Prevention Framework for Prescription Drugs grant program administered by DCTS; Prescription Drug/ Opioid Overdose-Related Deaths Prevention grant program administered by DCTS; the State Opioid Response grant program administered by DCTS; State Prevention Framework for Prescription Drugs grant program, and program to train first-responders and other key community sectors to prevent opioid-related deaths.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Regarding Question 3: No, DHS does not directly purchase any of the following medication. However, grantees have used SABG funds to purchase Buprenorphine, Methadone, and Naloxone for individuals without insurance.

DRAFT

NOT FINAL

Environmental Factors and Plan

DRAFT

15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

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-prevention 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 and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

NOT FINAL

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

All of the resources above are utilized within Wisconsin's county-based behavioral health system. In Wisconsin, Crisis Intervention (under DHS 34, subchapter III administrative rule) is available through three modalities, at minimum: 24/7 telephone services; 8-hour 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. There are one urban and five rural counties that do not participate in subchapter III services.

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 situation and to prevent the emergence of another. Crisis services have enabled diversion from a great many unnecessary psychiatric hospitalizations. In Wisconsin, in order 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). Some counties have youth beds available currently and there will likely soon be authority for the state Department of Health Services to license a small number of Youth Crisis Stabilization Facilities, Wisconsin Stats. Chapter 51.042.

Certified Peer Support Specialists. Administrative rules are not specifically prescriptive for peer services through Crisis Intervention in Wisconsin, but the state allocates funding resources to peer services. At this point, not many Crisis programs have Certified Peer Support (CPS) Specialists but other behavioral health programs do make broader use of CPS (e.g., Community Recovery Services and Comprehensive Community Services to name a couple). Additionally, the state has helped provide resources for the development of three Peer Run Respite Centers that often have warm lines. Crisis programs are encouraged to utilize peers in their emergency mental health programs. Suicide prevention, safety planning, and family engagement are implicit within the Emergency Mental Health Services Program or Crisis Intervention administrative rule (under DHS 34). With respect to Family-to-Family courses, there are a number of NAMI affiliates that provide these and other family support.

Crisis Improvement Learning Collaborative. In 2018, Wisconsin undertook a collaborative effort with counties to examine and disseminate ways to improve Crisis Services. Ten counties and the Human Services Counties Association partnered to study the ways Crisis services were being implemented across Wisconsin in the context of best practices described by SAMHSA and other authoritative sources. A Toolkit for Improving Crisis Intervention and Emergency Detention Services that is considered a work in progress was developed out of that collaboration. A series of mini-grant projects utilizing Community Mental Health Block Grant resources were launched out of that initiative which led to substantial improvements within a number of Crisis programs. Successful outcomes on the first round of these improvements has led to another round of rapid cycle quality improvement projects.

Crisis Intervention Team (CIT) Training. Under Wisconsin Act 126, $250,000 biennial general purpose revenue (GPR) was allocated for increased training for law enforcement in the 40-hour CIT for law enforcement and the Crisis Intervention Partners (CIP) training for correctional officers (see the CIT Wisconsin Website). There are two essential goals of the DHS initiative: 1) To increase the number of CIT-prepared law enforcement officers and CIP-prepared correctional officers in Wisconsin; and 2) To increase the number of trainers in Wisconsin—i.e., train-the-trainer—who are able to provide best practice CIT/CIP training. A number of goals are embodied within the goals of the project.

Crisis Services Workgroup. In 2019, the Department of Health Services developed a workgroup in partnership with the Wisconsin County Human Service Association focused on making improvements to the overall infrastructure for crisis services in the state. The workgroup is utilizing the Crisis Now model and toolkit to inform this work. The workgroup conducted a comprehensive survey of all county crisis programs in Fall 2019 and analyzed the data throughout 2020. This led to the creation of five priority

DRAFT
NOT FINAL

subgroups which are piloting infrastructure improvements throughout 2021.
988. Wisconsin is preparing for the implementation of the national three-digit dialing code for the National Suicide Prevention Lifeline (NSPL) network. Wisconsin has four Lifeline member call centers located in Wausau, Madison, Milwaukee and Green Bay that answer nearly all calls from Wisconsin residents who call the NSPL. Three of the call centers are independently operated and answer calls for small, local areas. One of the call centers is supported and funded by the Department of Health Services through Mental Health Block grant resources. This call center answers the remainder of calls for the state and also serves as a back-up call center for the other three call centers. By making the NSPL more accessible, an increase in demand is expected and a need for preparation and planning is underway.

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

DRAFT

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing 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 guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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 to the greatest extent possible, 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.

NOT FINAL

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) 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

DRAFT

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.

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?

Wisconsin has successfully completed creating an integrated (SMI and SUD) peer specialist training curriculum, selected independent peer trainers and has an integrated certification exam. The integrated parent peer specialist curriculum was completed in 2018 and revised and finalized in 2020 after the pilot phase. Peers were used in the development of the curriculum and in all areas of the peer specialist integration process. Wisconsin has also implemented a training curriculum and certification exam for Certified Parent Peer Specialists.

In addition, peers are involved in peer run respite, recovery centers, and the advisory task force embracing integration of peer services by welcoming both SMI & SUD. Peer specialists' services are reimbursed by Medicaid when they are provided in the psychosocial rehabilitation programs that serves both SMI and SUD – across the lifespan. Medicaid reimburses residential SUD services through the psychosocial rehabilitation programs and as a card service and supports the use of peers. Medicaid also reimburses peer specialists through the State Medicaid HMOs. In the near future, Medicaid will pay for peer recovery specialists (peer specialists and recovery coaches) to provide and be reimbursed for peer support services provided in a broader array of behavioral health services, not just psychosocial rehabilitation programs.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

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:

Please respond to the following items

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

DRAFT

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG 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.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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

NOT FINAL

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

DRAFT

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ◉ Yes ○ No

b) The recovery and 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) Juvenile justice? ◉ Yes ○ No

c) 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

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.)

Although Wisconsin has been developing collaborative systems of care since the early 1980s, the Governor's budget proposal (FY 2014-2015) included a significant investment in the Coordinated Services Team (CST) initiative to expand the program statewide. The Bureau of Prevention, Treatment, and Recovery, in collaboration with the Children Come First Advisory Committee (mandated by the CST legislation), developed a statewide expansion plan to expand integrated services. There are currently 67 Counties and 11 Tribes operating CST Initiatives in Wisconsin. Each initiative operates under a vision to implement a practice change and system transformation by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families involved in multiple systems of care. The vision of the Wisconsin system of care for children is Children and families are valued, understood, and supported in their communities. Along with implementation of the initiative each county and tribe establishes a local coordinating committee to oversee and advise the development of their initiative and local system of care.

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

NOT FINAL

months. In addition, crisis response plans for each child/youth are also required.

7. Does the state have any activities related to this section that you would like to highlight?

Wisconsin has been working towards creating a more seamless comprehensive children's behavioral health system and expanding work in the system of care after technical assistance was received by Georgetown University in 2015. The initial steps in this work has 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 tribes and counties can use to assess where they are at in the development of their local system of care. This information is then used by the state to make data-driven decisions in the provision and development of technical assistance. The state is also developing a resource library that will serve as a companion to the self-assessment tool. It has been six years since Wisconsin received technical assistance from Georgetown University; Wisconsin intends on hiring a consultant in 2022 to have a second system of care technical assistance forum to assess progress and to establish state-wide goals and objectives for the next five years.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT

NOT FINAL

Environmental Factors and Plan

DRAFT

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year 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 items:

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.

Note for question 1: An updated plan was released in September 2020.

The following MHBG-funded activities are intended to improve services and reduce suicide in the state:

1) Expand the systems change approach (e.g., Zero Suicide framework) to prevent suicide for individuals receiving services in health or behavioral health care settings.
2) Develop the mental health workforce through training in recognizing, assessing, managing, and responding to suicide risk.
3)Support a member center of the National Suicide Prevention Lifeline/988 that provides coverage (primary or back-up) for the entire state.

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ( ) Yes (•) No

If so, please describe the population targeted.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG 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 SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

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?

None at this time.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

DRAFT

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse 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 SABG, 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.**[69]

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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Initial planning steps involve the creation of a Mental Health and Substance Use Needs Assessment, and this past year the additional step of creating a Gaps Analysis was implemented. The Bureau of Prevention Treatment and Recovery further collaborates with the State Council on Alcohol and Other Drug Abuse (SCAODA) to inform the state's plans. The BPTR provides briefings on Substance Use treatment, recovery, and prevention services at SCAODA, and its sub-committees, meetings throughout the calendar year.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

2. 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

3. 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 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.

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

NOT FINAL

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 2020-2021 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. 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

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DRAFT

NOT FINAL

Environmental Factors and Plan

DRAFT

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.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Holly Audley	State Employees	Wisconsin Department of Health Services		
Jessica Barrickman	Providers			
Jerolynn Bell-Scaggs	Providers			
Kimberlee Coronado	Parents of children with SED/SUD			
Mark Eisner	State Employees			
Inshirah Farhoud	Others (Advocates who are not State employees or providers)			
Dennis Hanson	Providers			
Wendy Henderson	State Employees			
Richard Immler	Providers			
Kevin Kallas	State Employees	Wisconsin Department of Corrections		
Pam Lano	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)			
May Yer Thao	State Employees	WHEDA		
Peter Thao	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kristin Welch	Parents of children with SED/SUD			

NOT FINAL

Ana Winton	Others (Advocates who are not State employees or providers)			

DRAFT

Footnotes:

State Education Agency - Tim Peerenboom

State Vocational Rehabilitation Agency - Mark Eisner

State Criminal Justice Agency - Kevin Kallas

State Housing Agency - May yer Thao

State Social Services Agency - Wendy Henderson

State Health (MH) Agency. - Holly Audley

NOT FINAL

Environmental Factors and Plan

Advisory Council Composition by Member Type

DRAFT

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**25**	
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)	2	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	6	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**13**	**52.00%**
State Employees	7	
Providers	4	
Vacancies	1	
Total State Employees & Providers	**12**	**48.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The Wisconsin Council on Mental Health reviewed the application in August of 2021.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

DRAFT

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

c) Other (e.g. public service announcements, print media) ( ) Yes (•) No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

DRAFT

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] 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[3].

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[4]. 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[5]: 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.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,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.

NOT FINAL

End Notes

[1] 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.

[2] 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.

[3] 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)

[4] 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.

[5]***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;

DRAFT
NOT FINAL

- 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.

DRAFT

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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.

NOT FINAL

Environmental Factors and Plan

DRAFT

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL