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JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative John Nygren

Date: January 2, 2015

Re: OCMH Report to JFC

Attached is a report on the Office of Children's Mental Health, pursuant to 2013 Wisconsin Act 20.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

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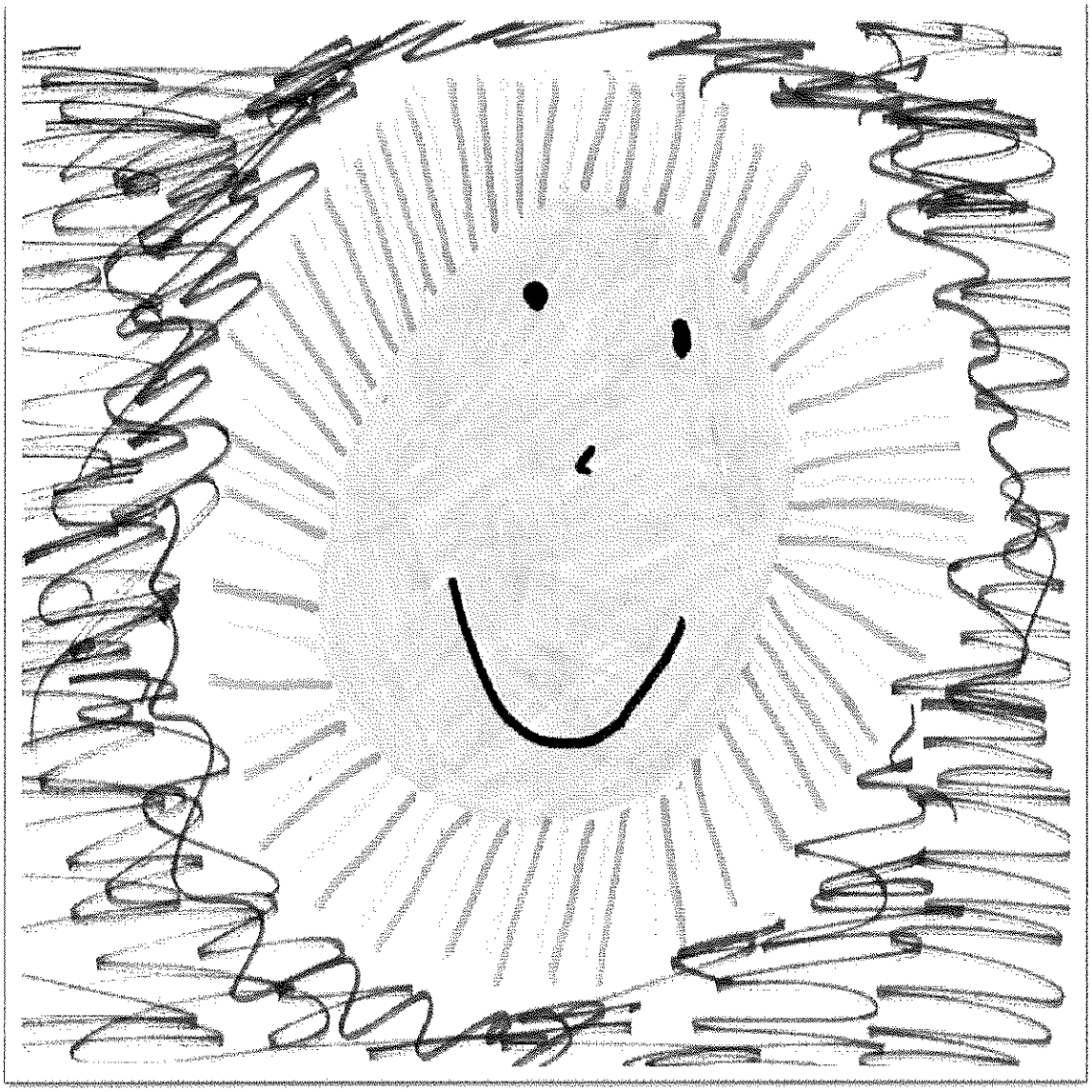
Office of Children's Mental Health

2014 Report to the Wisconsin Legislature



Wisconsin Office of Children's Mental Health
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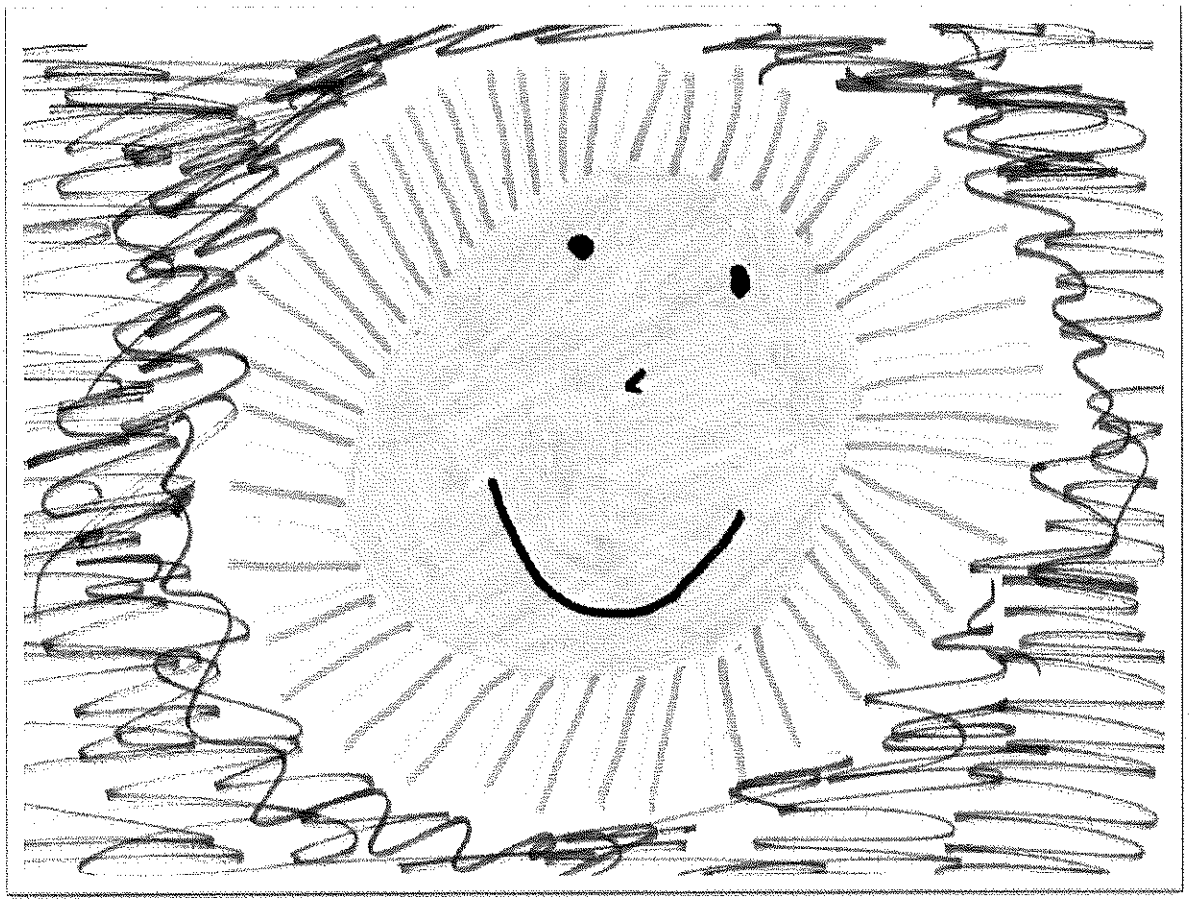
Office of Children's Mental Health

2014 Report to the Legislature

Dedication: We dedicate this report, as well as all of our work, to Wisconsin's children and families. Their positive social and emotional development is what will keep Wisconsin moving Forward.



Appreciation: One of our central partners in this first year has been the Wisconsin Department of Health Services. We at the Office of Children's Mental Health don't have the words to adequately express our gratitude to the DHS staff who have provided so much patience, guidance and assistance. Our future success will be grounded in these first months of kindness, generosity and hospitality.

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Executive Summary

At no time in recent history has there been the breadth and depth of Wisconsin governmental leadership in the area of mental health as was seen in the 2013-2015 biennial budget. The creation of the Office of Children's Mental Health (OCMH) was approved as just one part of this larger transformative mental health initiative outlined in 2013's ACT 20.

When Governor Walker learned that children with mental health issues were often lost in complicated systems, multiple agencies and disjointed services, he wanted a solution. Additional information showing that children were going un-served or under-served fueled the need for action. As a result, the OCMH was created to do the following:

- Improve children and families' access to services, with a focus on resources provided by the Wisconsin Department of Health Services (DHS); the Department of Children and Families (DCF); the Department of Public Instruction (DPI); and the Department of Corrections (DOC), as well as other Wisconsin organizations;
- Facilitate communication with all child- and family-serving state agencies, coordinate initiatives, and monitor program performance focused on children's mental health;
- Support administrative efficiencies to reduce duplication among child- and family-serving state agencies.

To acknowledge the urgency of our charge, OCMH established three action-based categories to structure the OCMH work: **Innovate, Integrate** and **Improve.**

The OCMH's commitment to ***innovation*** takes shape with activities focused on (1) meaningful family involvement in systems' change, (2) our perspective on children's mental health, (3) our adoption of a public health approach, and (4) our focus on system collaboration.

Our ***integration*** activities are grounded in Collective Impact, a change process designed to promote collaboration and coordination of child- and family-focused activities. The OCMH's service landscape will help stakeholders understand the shape and scope of the current child-serving system.

Identifying and understanding the child and family service data will guide our ***improvement*** efforts. Our initial work outlines some of the challenges we face:

- a shortage of mental health providers,
- high rates of children's psychiatric hospitalizations,
- high rates of sanctions for children with mental health issues,
- a youth suicide rate 40% higher than the national average,
- pronounced racial disparities in school discipline, juvenile detentions, and foster care placement.

While Collective Impact activities will provide OCMH's primary focus in 2015, several early issues have emerged that will be included in the OCMH's list of partnership activities: tracking the growing state-wide interest in school-based mental health, assisting in the development of parent peer specialists, monitoring the use of psychotropic medications in foster care and the examination of high rates of youth hospitalization.

This report outlines many of the challenges facing Wisconsin's child-serving systems while also highlighting the good work already underway. By combining stakeholder commitment and passion with the OCMH's call to action, we anticipate great things in 2015.

Introduction

The passage of Act 20 in 2013 was a watershed moment for mental health in Wisconsin. The various initiatives, including the creation of the Office of Children's Mental Health (OCMH), collectively symbolized Wisconsin's recognition of the centrality of positive mental health to a thriving citizenry and productive workforce.

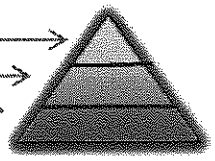
Additionally, Governor Walker hoped to raise awareness and build momentum around trauma-informed care and the widespread dissemination of material outlining the prevalence and impact of adverse childhood experiences (ACEs). More personally, the governor has supported First Lady Tonette Walker's commitment to improving the lives of Wisconsin's children and families through her leadership of Fostering Futures, a public-private partnership implementing trauma-informed care across the state. Ensuring the clear link between children's adversity and mental health difficulties is at the core of the OCMH operation.

MISSION, GOALS AND CONCEPTUAL FRAMEWORK

Mission: For many people, the implicit meaning of "children's mental health" is "children's mental illness." The OCMH intends to broaden the focus from mental health/mental illness to the promotion of children's social and emotional development. This is reflected in our mission statement: *The Office of Children's Mental Health supports Wisconsin's children in achieving their optimal social and emotional wellbeing.*

Goals: With the growing understanding of the role that early experiences play in shaping children's worldview and brain development, the OCMH established the following goals, each of which corresponds to a tier in the public health pyramid:

Tertiary: Increase access to effective children's mental health services
Secondary: Decrease toxic stress
Primary: Increase resilience



Conceptual Framework: Given our goal of population-based change, a sole focus on developing mental health providers' capacities and expanding access to mental health therapies is insufficient. The pyramid on page seven (Figure 1) illustrates the continuum of community involvement necessary to significantly improve the social and emotional wellbeing of Wisconsin's children. A description of each level follows.

Figure 1

Safe, Stable, Nurturing Families and Communities: The foundation of the pyramid identifies the most significant impact on the lives of children: the presence of safe, stable and nurturing parents or other caregivers. Research shows that stressors within the family—such as unaddressed parental mental illness, addiction, or domestic violence—can have profound and lasting consequences on a child's physical and mental health.[1] Yet too often parents are left with insufficient understanding of how their lives and challenges can impact their child, and subsequently what they can do about it. Similarly, research shows that providing support for a parent is one of the best ways to enhance the outcomes of a child.[2] Therefore, any approach to bolster children's mental health and social development needs to consider how best to support, educate, and advocate for parents. In addition, a complete public health approach to children's mental health must account for where and under what conditions children and families live. Research shows that the community a child grows up in can affect his or her mental and physical health.[3] Ensuring that our communities are safe, stable and nurturing is thus an important goal.

Skilled Child-Serving Workforce: The second layer of influence identifies any adults who touch the life of a child including early child care workers, teachers, after school services, coaches, members of civic organizations and faith communities, etc. The research on child development shows that having even one safe, stable and sensitive adult in a child's life can help make the difference between a child who is resilient and one whose life trajectory is far less hopeful.[4] Providing the child- and family-serving workforce with actionable information and skill-building about how best to support children's social and emotional development is therefore vital to helping create stronger, healthier children and future adults.

Youth and Parent Peer Specialists (PPSs): The third tier identifies PPSs, a relatively new resource for families. A PPS is a parent or caregiver of a child who has mental, emotional, or behavioral issues and

[1] National Scientific Council on the Developing Child. (2005/2014). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3. Updated Edition. Retrieved from www.developingchild.harvard.edu.
[2] Emde, R., and Robinson, J. Guiding principles for a theory of early intervention: A developmental-psychoanalytic perspective. In *Handbook of early childhood intervention*. 2nd ed. JP Schonkoff and S.J. Meisels, eds.
[3] Selected bibliographies available through the CDC Healthy Places webpage.
[4] Masten, A.S., and Reed, M. G. (2002). Resilience in Development. In S.R. Snyder & S. J. Lopez (Eds.), *The Handbook of Positive Psychology*. Oxford, England: Oxford University Press.

who is specifically trained to provide information, resources and support to other parents. This addition to the mental health/substance use workforce offers families and young people "peer-to-peer support" that may serve as an enhancement to traditional services or may be used as a stand-alone service. In addition to mental health/substance use, Wisconsin may also soon see the benefits of the PPS role in primary care, schools, child welfare and juvenile corrections.

Coaches and Consultants: Organizational leaders and service providers have discovered that a one hour or even one day training is often a lost investment without the addition of regular, direct, on-the-ground guidance. Implementation science identifies coaching as one of the most effective ways to change practices in the workforce.[5] Thus, OCMH sees an important role for coaches and consultants who can help translate insights from research and evidence-based practices into changes in the home, early educational setting, classroom and clinic.

Student Support Services: Schools are in a primary position to see the effects of students' social and emotional struggles; however, Wisconsin currently falls far below the recommended number of school psychologists, counselors, social workers and nurses to meet the full extent of students' needs. The OCMH sees student support personnel as a vital resource enabling students to reach their full potential.

Mental Health Providers (Psychiatrists, Psychologists, Counselors, Social Workers, etc.): Mental health providers represent the tip of the pyramid. Much like other areas across the country, Wisconsin's mental health workforce is largely insufficient to satisfy the need for therapies, psychological evaluations, psychiatric services, etc. For instance, 46 of Wisconsin's 72 counties are officially designated (or contain) Mental Health Professional Shortage Areas and data from the Wisconsin Department of Health Services indicates that the shortage is particularly pronounced for children.[6] For those families who do access services, there is no systematic data on what types of therapies or interventions are being used and how well they work. Given these factors, OCMH wants to both reduce the need for scarce mental health services by building the bottom of the pyramid, while also supporting the development of the right treatments, for the right children at the right time.

In many ways, the following report is a call to action and Wisconsin is primed to respond. The staff at the OCMH is honored to be a part of the state's unequivocal declaration that children's social and emotional wellbeing matters.

Please note: *Throughout this report, the reader may find unfamiliar words or acronyms. In some cases, we have embedded definitions; where we have not, we refer the reader to the Glossary located at the end of the report. Additionally, demographic information on Wisconsin's population and an explanation for the absence of tribal data appear in Appendix A.*

[5] See e.g. Joyce and Showers 1996 and 2002; Rodriguez and Knuth 2000; Garet et al 2001; Russo 2004.
[6] For information on shortage areas, see http://hpsafind.hrsa.gov/. For information on youth served in the public mental health system see http://media.samhsa.gov/dataoutcomes/urs/2012/Wisconsin.pdf.

Innovate

TRAUMA-INFORMED CARE: SHIFT YOUR PERSPECTIVE

The OCMH sees trauma-informed care as central to improving child and family outcomes and as highly relevant to every level of the aforementioned pyramid. Building on Wisconsin's trauma-informed care and Adverse Childhood Experience (ACE) momentum, the OCMH will carry forward the trauma-informed call to action: *Shift Your Perspective.*[7]

> *"I have had a very positive experience working with the OCMH. The Office is working on a paradigm shift in the area of mental health, one that is desperately needed for our children. What is currently out there is not working, so a new vision and new action are needed. I feel confident that with the experience and commitment of the OCMH, and the continued process of engaging families, eliminating the stigma of mental health issues can be done, and individuals will receive the support they need to live enriching lives."*
>
> *Helena Heo, OCMH Collective Impact Parent Partner*

Shift Your Perspective: Families as Leaders vs. Families as Receivers

In order to ensure family involvement in all aspects of operation, OCMH hired a Family Relations Coordinator who has personal experience navigating multiple systems of care for herself and her children. Her primary task is to ensure that families are meaningfully involved in every step of our work.

In many ways, this concept is not new to Wisconsin. The Department of Health Services, Division of Mental Health and Substance Abuse Services has promoted meaningful consumer involvement for many years. The Department of Public Instruction has the Wisconsin Statewide Parent Educator Initiative (WSPEI) created to educate and support parents of students with Individual Education Plans (IEPs). Other state agencies have ways of soliciting parent engagement at the service level. Additionally, Wisconsin has several organizations that are focused on meaningful family involvement. These include, but are not limited to: Family Voices of Wisconsin, National Alliance for Mental Illness (NAMI), Parent 2 Parent of Wisconsin, Wisconsin Family Assistance Center for Education, Training and Support (Wisconsin FACETS), Alianza Latina Aplicando Soluciones (ALAS), and Wisconsin Family Ties (WFT).

Our innovation lies in developing an infrastructure (e.g., recruitment, training and support) to ensure meaningful parent and youth involvement across all state-level activities related to the wellbeing of children and families. This activity is underway with the recruitment and training of ten parents and five youth who will provide leadership to Collective Impact activities. (See section entitled **"Integrate")** Additionally, the Family Relations Coordinator provides technical assistance to state agencies requesting assistance in increasing meaningful youth and family engagement.

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[7] See DHS, DMHSAS TIC website: http://www.dhs.wisconsin.gov/tic/.

Shift Your Perspective: Adaptation vs. Mental Illness

The OCMH encourages an enhanced understanding of children's mental health symptoms, diagnoses and treatment, including how we interpret and assign meaning to challenging or troubling behaviors. Specifically, we highlight research related to neurobiological adaptations resulting from early adversity. This perspective shift is in line with many of Wisconsin ACE activities that bring to light the following information:

- Forty-six percent of Wisconsin children have experienced at least one ACE,[8]
- Seventy percent of adult respondents with Medicaid report at least one ACE,[9]
- Medicaid recipients are more than twice as likely as residents with private insurance to report having four or more ACEs, which is correlated with poorer physical and mental health,[10]
- In 13 Wisconsin counties, one out of every five adults has four or more ACEs,[11]
- Approximately one in eight Wisconsin mothers of children on Medicaid had fair or poor mental health.[12]

This focus is central to our work because seeing and addressing only the child's decontextualized symptoms of toxic stress and trauma, without understanding the source of the behaviors, often results in negative outcomes such as re-traumatization, failed treatment, misguided sanctions, discouraged families, and frustrated staff.

A concrete example of the need for a system-wide shift in understanding would be to consider a single child who receives three different labels from three service systems for the same challenging behavior. These labels might include: *severe emotional disturbance* (SED - mental health system), *emotional behavioral disabilities* (EBD – educational system) or *criminality/criminogenic thinking* (Delinquent - correctional system). Across these systems, the standard assumption is, *"there's something wrong with this child"* since his/her behaviors clash with each system's behavioral expectations. OCMH aims to change the conversation by rethinking our categorical understanding and asking instead, *"what might have happened to this child that would explain this behavior?"* This shift brings systems together with shared language and a shared understanding of the child's underlying issues. Accountability and specific interventions will still be required, however the shift in understanding will lead to a more comprehensive understanding of what will and will not work.

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[8] Sacks, V., Murphey, D., & Moore, K. (2014) Adverse Childhood Experiences: National and State Level Prevalence. Child Trends Publication2014-28.

[9] O'Connor, C., Finkbiner, C., & Watson, L., (2012). Adverse Childhood Experiences in Wisconsin: Findings from the 2010 Behavioral Risk Factor Survey. Madison, Wisconsin: Wisconsin Children's Trust Fund and Child Abuse Prevention Fund of Children's Hospital and Health System.

[10] Ibid.

[11] Wisconsin ACE Brief 2011 and 2012 Data. Madison, Wisconsin: Wisconsin Children's Trust Fund and Child Abuse Prevention Fund of Children's Hospital and Health System.

[12] 13.3%. From 2011-12 National Survey of Children's Health.

Shift Your Perspective: Public Health Approach vs. Primarily Clinical Focus

With the public's growing understanding of the prevalence and impact of ACEs comes the growing awareness that clinical interventions are not enough. The skill development and relational strength necessary to create safe, stable and nurturing families and communities requires commitment from every adult who touches the life of a child. Thus, the OCMH has adopted a public health approach to improve children's mental health. This involves encouraging policies and practices that will build resilience for children and families, reduce and/or mitigate toxic stress and increase access to effective services for those children with identified mental health needs.

'I was positively impacted by a connection made over 30 years ago at a job where I was connected to a program for "at risk" students. The positive connections made with co-workers and managers changed my life! One example was a human resources vice president. He helped me believe in myself and recognize that I wasn't stupid as I once thought because of the struggles I experienced in school. He recognized my gifts, strengths and talents and brought them to light.'

Tina Buhrow, OCMH Collective Impact Parent

Shift Your Perspective: Systems vs. Programs

Improving children's mental health cannot be achieved by simply enhancing one program or starting a new initiative. Funders and change-agents now realize the importance of harnessing the synergy of multiple programs across many systems. This entails gaining a full understanding of what works, what areas need to be addressed, and which reform efforts are likely to be most effective. This effort will be outlined in more detail in the next section entitled **"Integrate."**

In many ways, our conventional approaches, though well intended, have not had broad and long-lasting impact. Ultimately, OCMH believes that provided with information and support, Wisconsin state agencies, communities and families will commit to reducing children's adversities, increasing protective factors, and improving services to ensure that our next generations are healthy and productive.

Integrate

COLLECTIVE IMPACT

In October of 2014, the OCMH and the Children's Trust Fund brought together approximately one hundred people to learn about a promising systems change strategy called Collective Impact (CI). The CI framework brings together cross-sector perspectives and facilitates the collective understanding of highly complex social problems involving multiple agencies and systems. The approach has been successful in many areas of the country (and abroad) and is used in several Wisconsin counties, nonprofits, and the University of Wisconsin to address issues such as poverty, education, and obesity.[13] Our CI project has the additional power of prioritizing youth and parent voices (Collective Impact Partners) in leading system innovation.

In preparation, the OCMH outlined the current system landscape (e.g., initiatives, collaborations, programs, number of children served, dollars spent)[14] using a continuum format from prevention to deep-end services. (A depiction of this landscape is located in Appendix B.) This process was enriched by the help of more than fifty analysts and other colleagues from multiple state agencies who attended an inter-departmental data meeting convened by the OCMH in July 2014. Having a visual depiction of this landscape begins to build a shared understanding of "the child and family-serving system" and promotes conversations and questions about possible gaps or duplication. Due to a lack of shared measures and the frequent absence of data around effectiveness, it is currently not possible to map these services in terms of outcomes. We hope that the CI process propels more programs to move beyond outputs to include evaluation of outcomes.

With this shared understanding of the service landscape, our CI partners will begin the first step in the CI process: the creation of a ***common agenda*** for change. (The agenda is also informed by the baseline data in the **"Improve"** section of this report.) Once the CI stakeholders agree on a common agenda, they identify ***shared measures*** for tracking progress and ***align efforts*** to ensure that different program areas are working towards the common agenda. ***Continuous communication*** between stakeholders helps to keep the process on track, and it is facilitated and supported by a ***backbone organization***. Our current interactions with stakeholders inspire confidence that Wisconsin is ready to engage in this promising approach.

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[13] Kania, John and Kramer, Mark, "Embracing Emergence: How Collective Impact Addresses Complexity" *Stanford Social Innovation Review*, January, 2013.

[14] Programs depicted here are those with an explicit link to a Wisconsin state agency. Future reports will include more information on programs that are specific to counties and tribes.

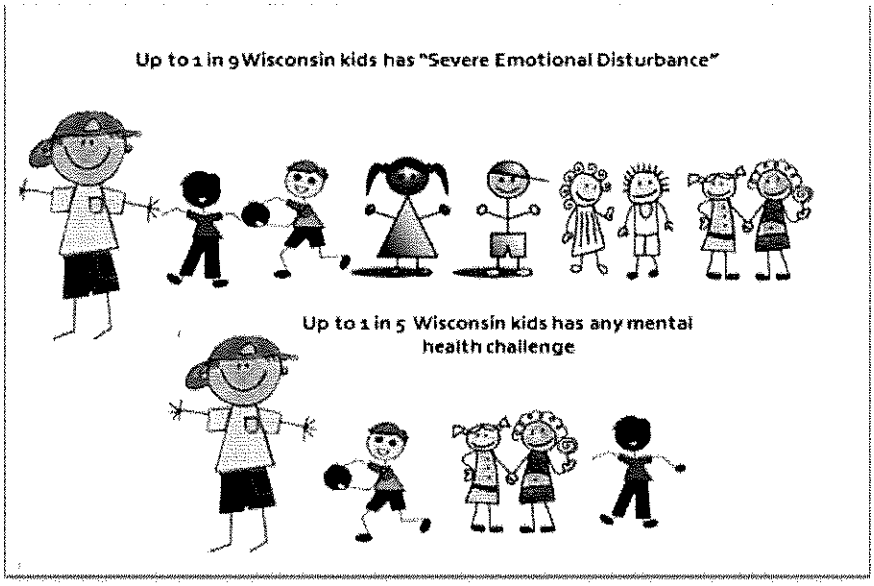
Improve

As outlined in the **"Integrate"** section, the Collective Impact participants will develop a common agenda for system change based on an understanding of how systems currently work and what can be improved. This section takes a step in that direction by outlining some of Wisconsin's available data related to the following: prevalence of mental health issues and other challenges, access to treatment, service outcomes, indicators of unmet needs, and indicators of system improvement.

A Note on Data: *The information that follows is drawn from individual programs. In order to create a comprehensive understanding of the scope and impact of our services, Wisconsin needs to develop the ability to look at data across service systems. There are currently several projects aimed at improving data quality and accessibility; OCMH is helping to move these efforts forward where they currently exist and encouraging them where they do not.*

PREVALENCE OF MENTAL HEALTH ISSUES, SUICIDE AND RISK FACTORS

Figure 2



Mental Health Issues: National estimates indicate that as many as one in five children has a diagnosable mental health issue.[15] The Substance Abuse and Mental Health Service Administration (SAMHSA) estimates the prevalence of childhood Serious Emotional Disturbance (SED) in Wisconsin at nine to eleven percent (See Figure 2); in terms of Wisconsin's population, this would be from 60,395 to 73,816 children ages nine to seventeen.[16]

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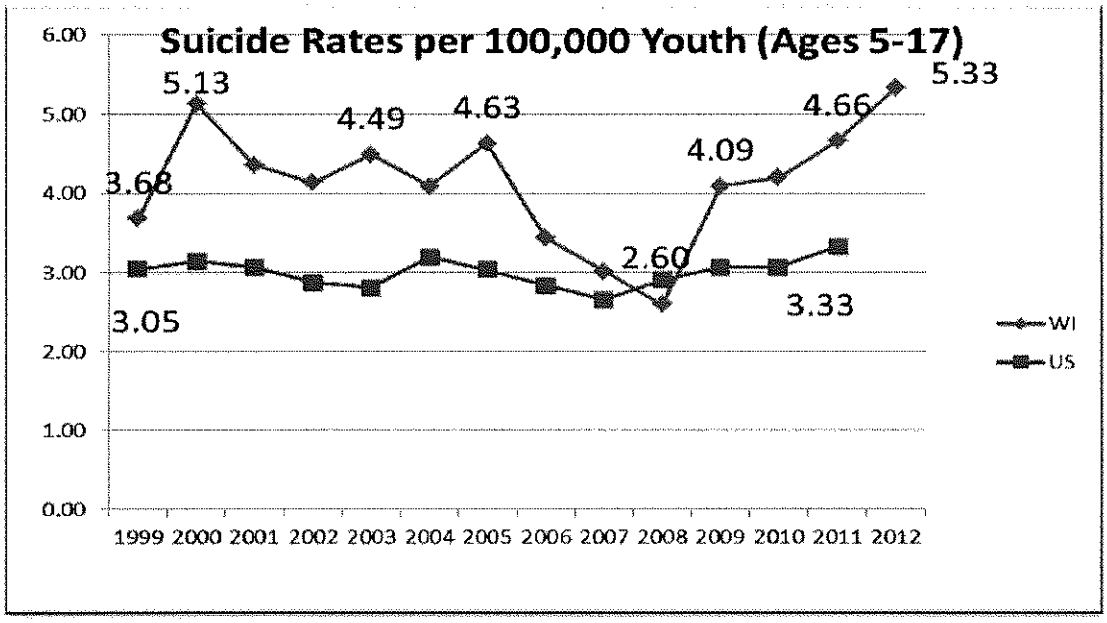
[15] CDC and Prevention, "Mental Health Surveillance Among Children—United States, 2005-2011." May 17, 2013, 62(02): 1-35.
[16] SAMHSA URS Table 1: Number of Children with SED, age 9 to 17, by state, 2013.

Data from the 2013 Wisconsin Youth Risk Behavior Risk Survey (YRBS) indicates that approximately one in four high school students experienced symptoms of depression[17] while just over half (55.6%) of students reported experiencing poor mental health at least one day in the last month. For lesbian, gay, or bisexual students, the numbers increase to more than one in two experiencing symptoms of depression (57%) and more than four out of five (83%) experiencing poor mental health days in the last month.[18] One in four female students reported intentionally injuring herself, such as cutting or burning.[19] With regard to substance use, 18% of students reported binge drinking in the past 30 days.[20]

Suicide: In Wisconsin, approximately one in eight students reported seriously considering suicide.[21] While the number of Wisconsin youth contemplating or attempting suicide is lower than the national average,[22] Wisconsin's actual youth suicide rate is 40% higher than the national average[23] (See Figure 3) and is the second leading cause of death for Wisconsin young people after accidents.[24]

Figure 3



[17] Students in this category answered affirmatively to the question of whether at any time in the past 12 months they had felt so sad or hopeless that they had stopped engaging in their usual activities.
[18] DPI, "Youth Risk Behavior Survey Executive Summary 2013," p. 3.
[19] Ibid, p. 2.
[20] Ibid, p. 4.
[21] Ibid, p. 3.
[22] Seriously considering suicide: 13.2% in WI vs. 17.0% U.S. Attempted suicide: 6.0% in WI vs. 8.0% U.S. Source: 2013 YRBS, available at CDC Youth Online YRBS.
[23] Source: Graph courtesy of Dr. Kathryn Bush of DPI. Rates calculated based on DHS Wisconsin SH Query system and CDC Wisconsin SQARS. See DPI's 2013: YRBS Executive Summary and CDC Youth Online High School YRBS Wisconsin United States 2013 results.
[24] Data query for 2013 from DHS WI SH system.

Suicide is particularly serious among lesbian, gay, bisexual or transgender youth (LGBT). In 2013, four out of ten LGBT youth reported that they had made a plan to commit suicide, and 28% had actually made an attempt. This is seven times higher than their heterosexual counterparts.[25]

Adverse Childhood Experiences (ACEs): Children with two or more ACEs are more likely to repeat grades, to have behavioral problems, and to suffer chronic health issues, including ADHD.[26] Almost one-half of Wisconsin's children (46%) have experienced at least one ACE and approximately one in nine children (11%) has experienced three or more ACEs. One place where ACEs are ubiquitous is in the area of juvenile corrections. The Wisconsin Department of Corrections (DOC), Division of Juvenile Corrections (DJC) recently administered ACE questionnaires to youth at their two juvenile facilities. The results revealed that trauma in general—and multiple traumas in particular—were a near universal experience for their youth.[27] Only two percent of youth at Lincoln Hills or Copper Lake Schools reported having experienced zero ACEs (vs. 46% of Wisconsin youth in general), whereas almost two-thirds (64%) had experienced three or more ACEs.

Lead Exposure: Research shows links between lead exposure, behavior problems and mental health concerns including anxiety, depression, aggression, hyperactivity, and anti-social behavior.[28] According to 2013 figures from the Centers for Disease Control and Prevention, Wisconsin's confirmed rate of lead poisoning is 45% higher than the national average (0.81% vs. 0.56%).[29] Over the last three years, 17,000 Wisconsin children have tested positive for lead exposure[30] prompting the governor to declare Oct. 19-25 Wisconsin Childhood Lead Poisoning Prevention Week.

ACCESS TO PUBLIC MENTAL HEALTH PROFESSIONALS AND SERVICES

While a wide array of child- and family-oriented programs and services exist across Wisconsin, there is still a substantial gap when it comes to children's mental health services. Approximately one in three children with a mental health need went without treatment in the past year.[31] When looking only at Wisconsin youth with a major depressive episode, nearly 60% did not receive treatment within the past year.[32]

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[25] DPI, 2013 YRBS Executive Summary, p. 3.
[26] Bethell, C.D., Newacheck, P., Hawes, E., Halfon, N. Adverse Childhood Experiences: Assessing The Impact On Health And School Engagement And The Mitigating Role Of Resilience. *Health Affairs*, 2014; 33 (12): 2106. DOI: 10.1377/hlthaff.2014.0914.
[27] ACEs scores for all Wisconsin children taken from Child Trends 2014, p. 4. DOC data is based on youth at Lincoln Hills and Copper Lake Schools from February 2013-January 2014.
[28] See an annotated bibliography of the literature on this topic at DHS "Lead-Safe Wisconsin".
[29] Centers for Disease Control and Prevention National Surveillance Data on Lead. "Number of Children Tested and Confirmed EBLLs by State, Year, and BLL Group, Children < 72 Months Old". Figures based on 2013 data and Blood Lead Levels ≥10 mg/dL.
[30] DHS, "Lead-Safe Wisconsin."
[31] The 2011/2012 National Survey of Children's Health reports that 65.4% of Wisconsin children ages 2-17 with problems requiring counseling received mental health care. This is also on par with the national estimate of 61% (the difference between them is not statistically significant).
[32] SAMHSA, "Behavioral Health Barometer Wisconsin 2013," p. 6.

County-based Services: Forty-six of our 72 counties include federally designated mental health professional shortage areas.[33] Looking at mental health providers (i.e., for adults and children), Wisconsin has 1,033 providers per capita versus a national average of 790: 1. According to one source, this places us 42nd nationally.[34] There is some evidence that the shortage is particularly pronounced for children. For instance, in 2013 six counties reported not serving any children in their mental health system, and an additional three counties served only two or three children.[35] In a consumer satisfaction survey for parents of children served in the public mental health system,[36] 68% of Wisconsin parents felt positive about accessing treatment, which is nearly 18 percentage points below the national average.[37]

Medicaid: When Wisconsin children access mental health treatment, 2013 claims data indicates that Medicaid is the primary payer, playing a greater role in paying for children's mental health services than other types of children's health services.[38] A recent report on mental health systems gave Wisconsin high marks for having almost universal insurance coverage for children,[39] although there is some indication that Wisconsin might be slipping in that regard.[40] While having some insurance is undoubtedly better than having no insurance, having Medicaid can be a barrier to receiving services. Several studies show that children with public insurance have to wait longer and have fewer available treatment options, attributed in part to providers declining to accept Medicaid patients if they believe the reimbursement rates are too low.[41] For instance, in a small poll of Wisconsin health care providers, 81% reported difficulty in finding a psychiatrist for their pediatric patients on Medicaid compared to 44% who reported finding it hard to find a psychiatrist for their privately insured patients.[42]

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[33] DHS, Division of Public Health, "Wisconsin Mental Health HPSAs: Federally Designated Health Professional Shortage Areas." May 29, 2013.

[34] Mental Health America, "Parity or Disparity: The State of Mental Health in America 2015," p. 40.

[35] Data query through DHS's PPS Mental Health Module.

[36] Milwaukee and Dane counties are under-represented in this sample.

[37] SAMHSA's 2012 URS tables. The survey only included children served by county employees or contractors. Many children with Medicaid see private providers; no surveys are currently conducted of those services. Milwaukee and Dane counties are under-represented in this sample.

[38] Based on a query of children ages 0-17 from the Wisconsin Health Information Organization (WHIO) data system, which includes public and commercial claims data from 70% of Wisconsin residents. The Wisconsin findings are in line with national figures suggesting that Medicaid is the single largest payer for children's behavioral health services. See e.g. AHRQ Statistical Brief #434: "The Five Most Costly Children's Conditions, 2011." April 2014.

[39] Mental Health America. "Parity or Disparity: The State of Mental Health in America 2015". The combination of near universal insurance coverage and high levels of identifying children with EBD in the schools leads to Wisconsin's children's mental health system being ranked third nationally, despite the fact that Wisconsin is average on most of the other measures and poor on excluded measures, such as hospitalization readmissions and workforce shortages.

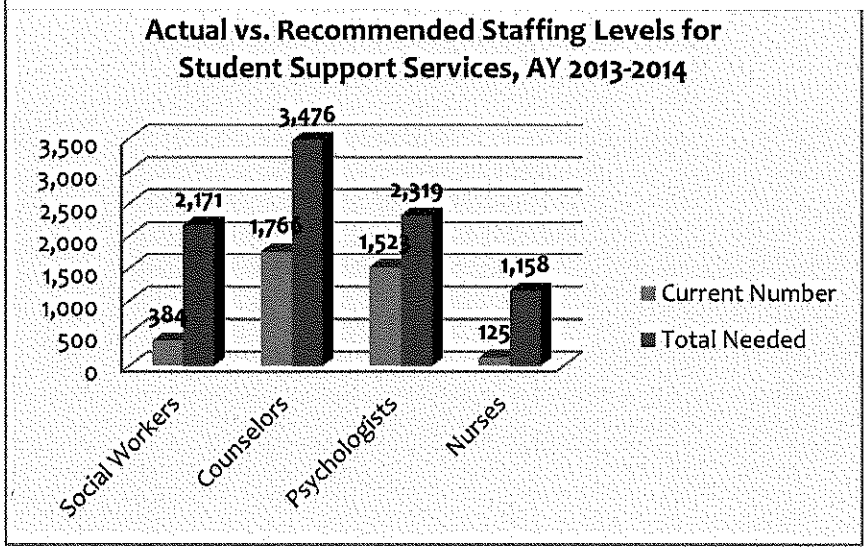
[40] See e.g. Alker, Joan and Alisa Chester. "Children's Coverage at a Crossroads: Progress Slows." Georgetown University Health Policy Institute, November 2014.

[41] See e.g. Bisagaier, J. & Rhodes, K.V. (2011) Auditing access to specialty care for children with public insurance. *The New England Journal of Medicine* 364: 2324-33.

[42] Poll conducted by the Wisconsin Statewide Medical Home Initiative, December 2014. Sixty-three physicians and pediatric nurse practitioners responded.

National data indicates that when children do receive professional social and emotional support, they are most likely to receive it at school through student support services.[43] Unfortunately, Wisconsin schools' workforce falls short of recommended staffing levels. For instance, on average each school counselor has nearly 500 students when the profession recommends working with 250 or fewer. Based on conservative estimates, Wisconsin schools would need nine times as many nurses,[44] five times as many social workers, twice as many school counselors, and 50% more psychologists to be adequately staffed (See Figure 4).[45] According to the most recent estimates available, Wisconsin ranked 12th in school psychologists staffing,[46] 37th for counselors,[47] and 41st for school nurses.[48]

Figure 4



SERVICE OUTCOMES

The following section highlights four outcomes: functional improvement, caregiver satisfaction with outcomes, reasons for leaving programs, and success in moving children to the least restrictive setting. ***Please note*** *that not all public programs collect data on service outcomes and when they do, reporting is not uniform making comparisons difficult.*[49] *In addition, there is little information on what types of therapeutic approaches are being offered.*[50] *Thus, what follows is a partial representation of treatment outcomes for programs based on available data.*

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[43] Hurwitz, Laura and Karen Weston. "Using Coordinated School Health to Promote Mental Health for All Students." *National Assembly on School-Based Health Care.* July 2010, p. 6.

[44] Based on a 750:1 student-to-nurse ratio from the National Association of School Nurses. This is the estimate for "well students"; the recommendation for students in Special Education is actually 225:1.

[45] National Association of School Psychologists (NASP) Communique. McGraw, Kelly and Daniel A. Koonce, "Research-Based Practice: Role of the School Psychologist," Vol. 39, Issue 8, n.d. The American School Counselor Association Student-to-Counselor Ratio 2010-2011. National Association of Social Workers Standards for School Social Work Services, 2012.

[46] Charvat, Jeffrey L. "Ratio of Students Per School Psychologist by State: Data from the 2009-10 and 2004-05 NASP Membership Surveys," April 2011.

[47] American School Counselor Association. "Student-to-School Counselor Ratio 2010-2011," n.d. State-by-state data on staffing of school social workers is not available.

[48] National Association of School Nurses, "Healthy Children Learn Better!" January 2009.

[49] One example of an effort to examine cross-systems outcomes comes from the Birth to 6 Initiative, which brings together the Birth to 3 Program and other DHS early childhood programs and Special Education programs sponsored through DPI.

[50] This problem is not unique to the public system. There is very little information on the private system's activities and effectiveness.

Functional Improvement: Both the Birth to 3 Program and Special Education Early Childhood programming (ages 3-6) report the number of children with social emotional challenges who improve during the course of treatment. In the Birth to 3 Program, slightly more than half the children (56%) showed substantial improvement on social emotional functioning during the course of treatment.[51] Recent data from Special Education Early Childhood programming shows that approximately 78% of preschoolers who entered school with a likely social emotional issue[52] showed improvement by age 6, however even with such improvement only one-third to 40% of these children were operating at grade level by the time they turned 6 or exited the program.[53] The vast majority (85%) of youth in Wraparound Milwaukee, Milwaukee's coordinated service approach, showed statistically significant improvement in clinical outcomes.[54] Other agencies collect data that identifies functional improvement but appear not to have a formal reporting process.[55]

Caregiver Satisfaction: An important treatment outcome is whether a child's caregiver sees improvement. In 2012, fewer than half of parents (42%) believed that their child's behavior and functioning had improved with county-based services.[56] Nationally, this places Wisconsin near the bottom for parent satisfaction.[57]

Wraparound Milwaukee administers its own series of consumer satisfaction surveys. At six months, the majority of families answered affirmatively to the statement, "Overall, I feel the care provided to me/my family has been helpful so far" (score: 4.65/5). At discharge, respondents were similarly positive about having made significant progress (4.07); meeting the child's educational needs (3.73) and being better able to handle challenging situations (4.33).[58]

In 2012, the Birth to 3 Program reported that approximately 90% of parents agreed that early intervention services helped their child develop and learn.[59] The DPI captures parental satisfaction

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[51] Wisconsin Annual Performance Report IDEA Part C, FFY 2012. Indicator 3, Outcome A. See p. 16.
[52] Defined here as children labeled as having an Emotional Behavioral Disability or Other Health Impairment. See greater descriptions of these categories in the glossary.
[53] DPI: OSEP Outcome 7A Indicators for Academic Year 2012-13.
[54] Based on repeat administration of the Child Behavioral Checklist Youth Self-Report. Kamradt, Bruce, "Innovative Approaches to Measuring and Monitoring Outcomes for Youth in Systems of Care: Wraparound Milwaukee's Model." Presentation in Albany, NY on October 8, 2014.
[55] For instance, DCF's DSP also assesses children's needs using the Child and Adolescent Needs and Strengths (CANS) tool for children in out-of-home care. Since most children are administered multiple CANS, the assessment theoretically provides a way to track improvement. DHS's Children's Long-Term Support Waivers also collect data on functional improvement through the Functional Screen. DHS will begin reporting out on various improvements for enrollees in the CCS program in 2015.
[56] DHS's Youth Satisfaction Survey for Families (YSS-F) surveys parents and caregivers whose children have utilized the county mental health system. It should be noted that the survey is not offered at discharge (as is true for other states using this survey), so some children may still be undergoing treatment when parents are surveyed.
[57] SAMHSA URS tables. The survey excludes those served through Wraparound Milwaukee or Dane County's wraparound program, Children Come First. In general, Dane and Milwaukee counties are under-represented in this sample. Also, not all states deploy a rigorous sampling methodology which could affect Wisconsin's national ranking. However, even when comparing Wisconsin to other states that do deploy such a methodology, Wisconsin ranks at or near the bottom.
[58] Wraparound Milwaukee 2013 Quality Assurance/Quality Improvement Annual Report. Dane County also collects consumer satisfaction data, but it was not available at the time of this publication.
[59] DHS, "Annual Performance Report: IDEA Part C," FFY 2012-2013, p. 7.

with the special education process (i.e., family involvement in planning), but not satisfaction with outcomes, which they instead measure directly via student improvement.[60]

Other areas where satisfaction surveys would be useful include: Children's Long-Term Support Waivers, Home Visiting, Child Protective Services, Emergency Detentions, psychiatric hospitalizations, crisis services, and juvenile detentions.

Reasons for Ending Services: Another indication of whether a program has met participants' needs is the reason for discontinuing services. Ideally, families end services because their children's needs have been met. Coordinated Service Teams (CSTs) report fewer than half of the youth who were discharged did so because their treatment goals had been met (43.4%).[61] Dane County's wraparound approach, Children Come First, reported that 56.6% disenrolled because they made "substantial progress."[62] Several other programs collect but do not report this measure. These include the Birth to 3 Program, Wraparound Milwaukee, Comprehensive Community Services (CCS), and general county mental health treatment services.

Least Restrictive Services: Returning home or into the community is another indicator of program success. While sometimes necessary, a placement in a psychiatric facility, residential care center, juvenile detention facility, shelter care, foster home, or other out-of-home placement can be stressful for a child and his or her family.

Wraparound Milwaukee has demonstrated success in ensuring permanent placements for children and reducing juvenile justice contacts and hospitalizations. In 2013, 70% of the 33 children in CSTs who were living out of home at the time of enrollment were back in the community by the time they ended services.[63]

DCF's Division of Safety and Permanence (DSP) supports children in foster care, residential care centers (RCCs) and other out-of-home settings. In 2013, RCCs successfully transitioned two out of three children (66.5%) to a less restrictive settings, 13.5% remained at the same level and 18% were transitioned to a more restrictive environment.[64] Fewer than half of the children in group homes (41.8%) transitioned to a less restrictive environment.[65] While the concept of a less restrictive setting is not as applicable to foster homes, DSP does capture similar measures for level Three and Four foster homes (known as "Child Placing Agencies" and formerly called Treatment Foster Homes). Just under half of those placements (45%) resulted in a child achieving permanence or being placed with a relative caregiver.

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[60] DPI, "State of Wisconsin Part B. Annual Performance Report, 2012-2013."
[61] DHS Division of Mental Health and Substance Abuse Services, "Children Come First Advisory Committee 2013 Annual Report on CSTs (pre-expansion)," p. 16.
[62] "Children Come First-Dane County 2013 Evaluation Indicators Report," p. 2.
[63] DHS Division of Mental Health and Substance Abuse Services, "Children Come First Advisory Committee 2013 Annual Report on Coordinated Service Team Initiatives (Pre-Expansion)," p. 11.
[64] DCF Residential Care Center Dashboard, Calendar Year 2013.
[65] DCF Group Home Performance Based Measures Dashboard, Calendar Year 2013.

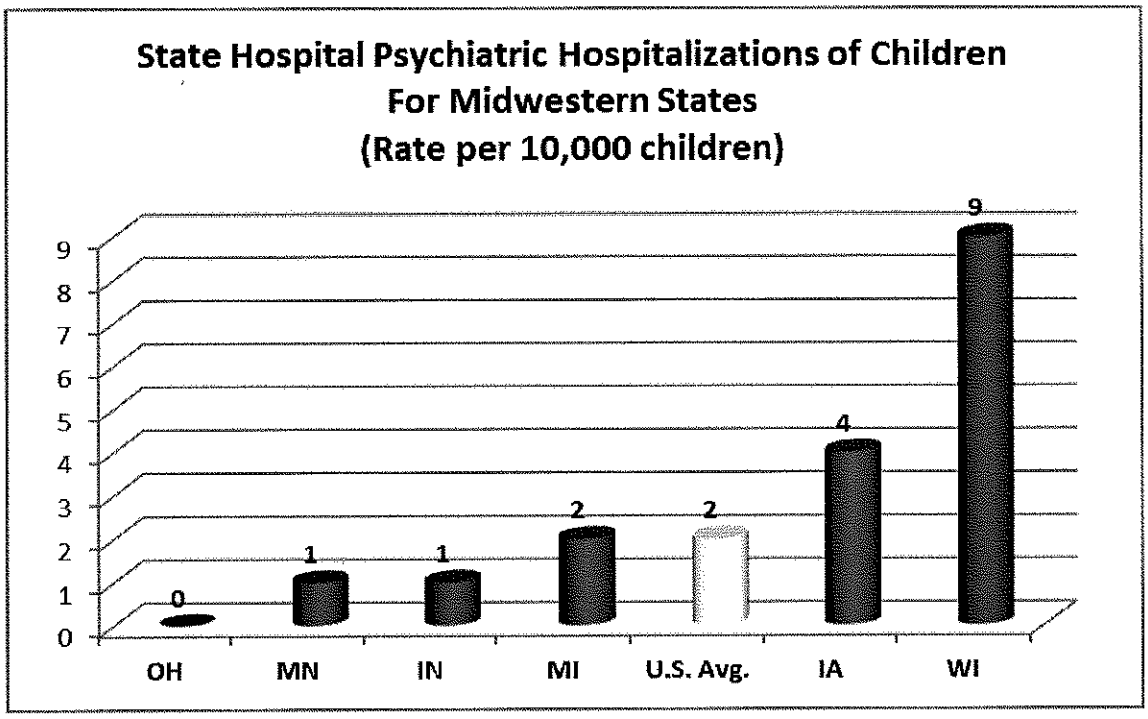
There are many other types of outcomes that are important to capture in order to evaluate systems and programs. In future years, we hope that there will be broader data collection, integration, and reporting to allow for further analysis.

INDICATORS OF UNMET NEEDS

Over time, when children's social and emotional difficulties are unrecognized or inadequately addressed, there is a higher probability that families, providers and educators will become frustrated resulting in reactive, extreme and often punitive actions. With few available options, the "solutions" are generally crisis-driven, expensive, and effective only in the short-term, if at all. We examine some of these approaches below.

Psychiatric Hospitalizations: Wisconsin has higher than national average rates of psychiatric hospitalizations for children and youth. Looking only at the state psychiatric hospitalizations,[66] Wisconsin's rate of hospitalizing children and youth is 4.5 times the national average and the highest in the Midwest. (See Figure 5)

Figure 5

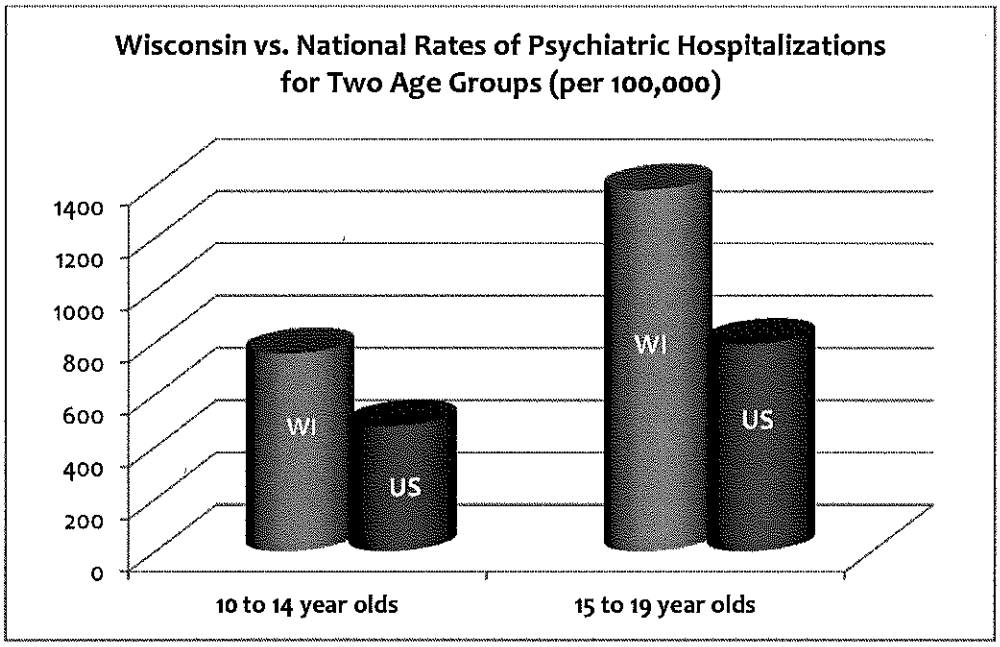


[66] As per federal reporting guidelines "state hospitalizations" refers to consumers admitted to both state and county hospitals; i.e., to all hospitalizations in public facilities.

More than one in four (27%) patients in public psychiatric hospitals is under 18 years of age, in contrast with the 1 in 14 (7%) national average.[67] In general, Wisconsin children served in the public mental health system are 2.8 times more likely to be admitted to the state psychiatric hospital than adults.[68] Wisconsin's 30-day hospital readmission rates for children are approximately twice the national average (14.6% versus 7.1%)[69] suggesting that hospitalization is a short-term answer to more entrenched problems.

While the aforementioned statistics are based solely on the public mental health system, the same general pattern holds when looking across all Wisconsin hospitals, with overall psychiatric hospitalization rates anywhere from 26% to 75% higher than the national average, depending on the year and the age group used.[70] (See Figure 6)

Figure 6

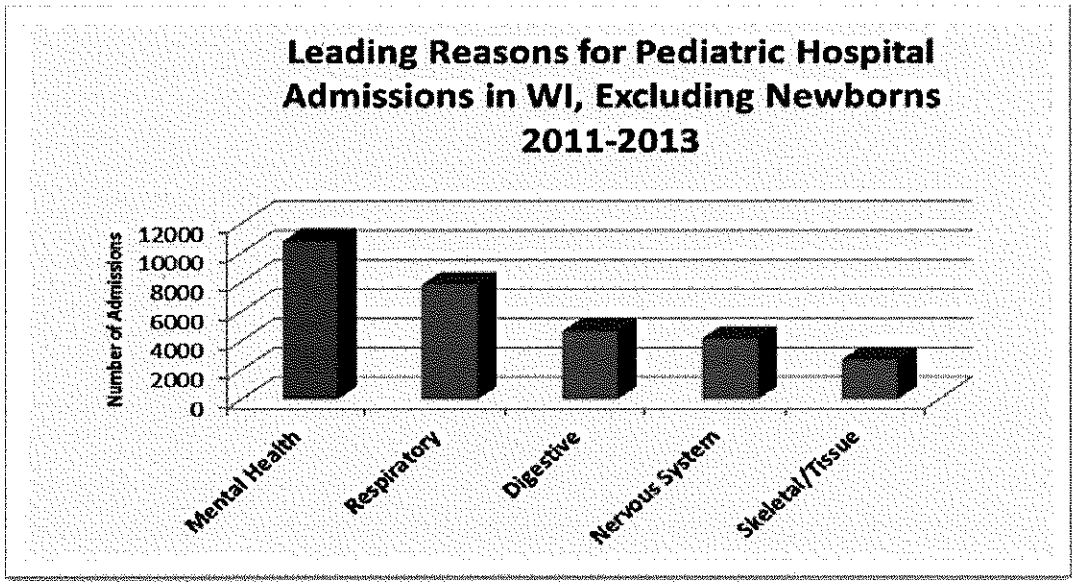


Based on available Wisconsin insurance claim data, mental health is one of the leading reasons for children's hospital admissions, second only to hospitalizations for newborns. Notwithstanding neonatal admissions, mental health hospitalizations constitute 15% of commercially covered inpatient

[67] See SAMHSA's 2012 URS table for Wisconsin. "Access Domain: Persons Served in State Psychiatric Hospitals by Age and Gender, FY 2012." As noted in the previous footnotes, this measure includes other public hospitals beyond the state facility.
[68] I.e., 10.7% of kids vs. 3.8% of adults served by the county system in 2012. Calculated from SAMHSA's 2012 URS tables based on the total number of adults vs. youth hospitalized in the state facility, out of the total number served through the county-based mental health system.
[69] Ibid. See "Readmission Rates."
[70] Based on the most recent (2009) national comparison: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Child Health USA*, 2011. Rates based on Wisconsin Hospital Association 2009 discharge data for all psychiatric inpatient admissions (MDC=19).

stays and 25% of Medicaid-covered admissions for those ages 0 to 17.[71] This contrasts with the most recent national data (2011), which puts mental health as the 5th leading reason for hospitalizations among children one year or older.[72] (See Figure 7)

Figure 7



DHS and DCF have recently begun investigating these high rates of hospitalization and have made preliminary recommendations to address this issue.

Out-of-Home Care: When a caregiver is unable to keep his/her child safe, child protective service must step in. Approximately 6,200 Wisconsin children are in out-of-home care at a given point in time[73] and approximately one of every five foster children comes back into the system after having been reunified with her/his parents.[74] This family upheaval often leaves children feeling helpless and hopeless with few coping strategies often resulting in challenging behavior. Thus, it is not surprising that children in foster care are more likely to be prescribed psychotropic medications.[75] In Wisconsin, more than one in four foster children (28.9%) were prescribed a psychotropic medication in 2013, versus 8.2% of non-foster children on Medicaid.[76]

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[71] Wisconsin Health Information Organization (WHIO) data. Query of all admissions by insurance type for ages 0-17 for 2011-2013.

[72] Clark, Cheryl. "Top 10 Reasons for Pediatric Hospitalizations". August 15, 2011. Available online at http://www.healthleadersmedia.copage-2/LED-269728/Top-10-Reasons-For-Pediatric-Hospitalizations.

[73] DCF, "Wisconsin Children in Out-of-Home Care" 2012 Annual Report. Dated December 31, 2013. Point-in-time estimates are based on Dec. 31 of each year.

[74] DCF, "Kidstat Performance Report: January-June 2014," p.19.

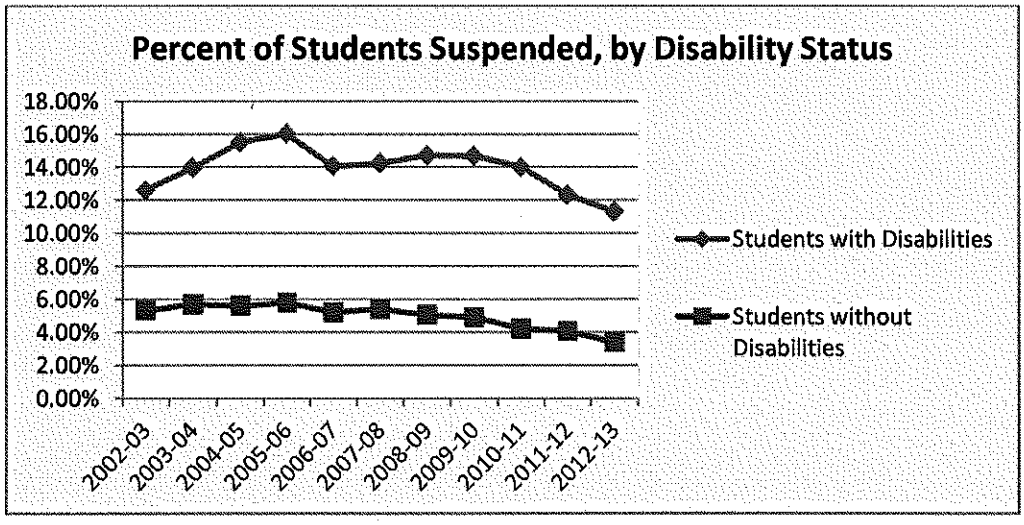
[75] Office of Planning, Research and Evaluation; Administration for Children and Families. "Child Well-Being Spotlight" August 15, 2012. For preliminary research specific to Wisconsin, see Mandell, Kara and Elizabeth Feder, "County level disparities in the prescription of antipsychotic drugs among children on Medicaid in Wisconsin," Presentation at the American Public Health Association Annual Meeting, Nov. 4, 2013.

[76] Analysis conducted by DHS Office of Health Informatics. Numbers do not include children prescribed stimulants.

School Discipline: One area of particular concern to parents and educators is the use of disciplinary action. Research indicates that this concern is validated as students who are suspended or expelled are at an increased risk of dropping out.[77]

- **Suspensions and Expulsions:** Statewide, students with any form of disability (e.g., emotional/behavioral disability, learning or cognitive disability, etc.) are at an increased risk of suspensions and expulsions compared to their peers who are not in Special Education. (See Figure 8)

Figure 8



The good news is that suspensions have been decreasing for all students. At the same time, schools are not closing the gap between students with disabilities and their peers. On the contrary, that gap has increased in recent years: whereas in the 2002-03 school year, students with disabilities were 2.38 times more likely to be suspended than their peers, in 2012-13 they were 3.35 times more likely to be suspended. This is higher than the national rate which was 2.2 times in 2011-2012.[78]

DPI tracks the number of students with disabilities who are suspended or expelled for a total of ten days or more. This is a severe and relatively rare discipline which threatens to disrupt a child's academic career. Students with an Emotional Behavioral Disability (EBD) designation are at the highest risk of receiving these school sanctions. Students with an EBD label made up only 10.4% of students with a disability, but represented approximately a third (32.8%) of extended suspensions and expulsions in this group.[79] (See Figure 9)

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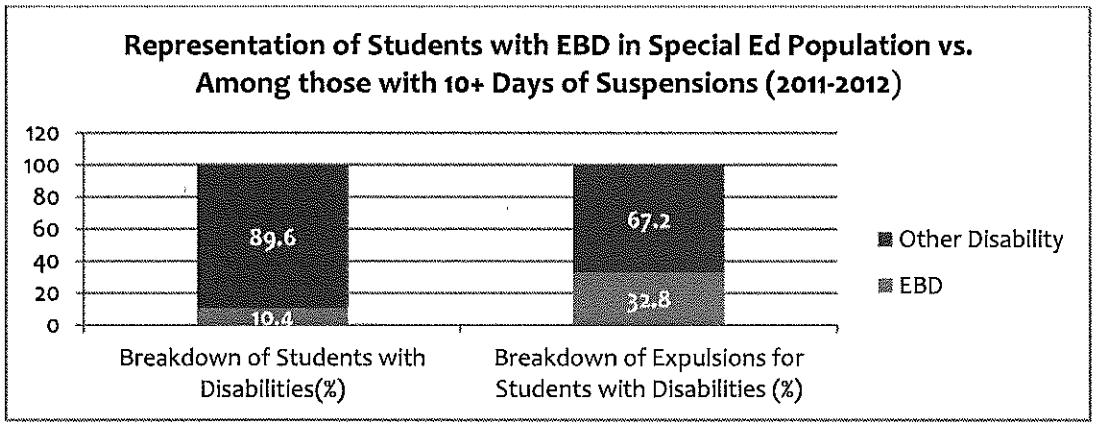
[77] Balfanz, R., Byrnes, V., & Fox, J. 2013. Sent Home and Put Off-Track: The Antecedents, Disproportionalities, and Consequences of Being Suspended in the Ninth Grade. Center for Civil Rights Remedies and the Research-to-Practice Collaborative. Available at: http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/summary-reports.

[78] U.S. Dept. of Education Office for Civil Rights. "Civil Rights Data Collection: Data Snapshot (School Discipline)," March 21, 2014, p. 3.

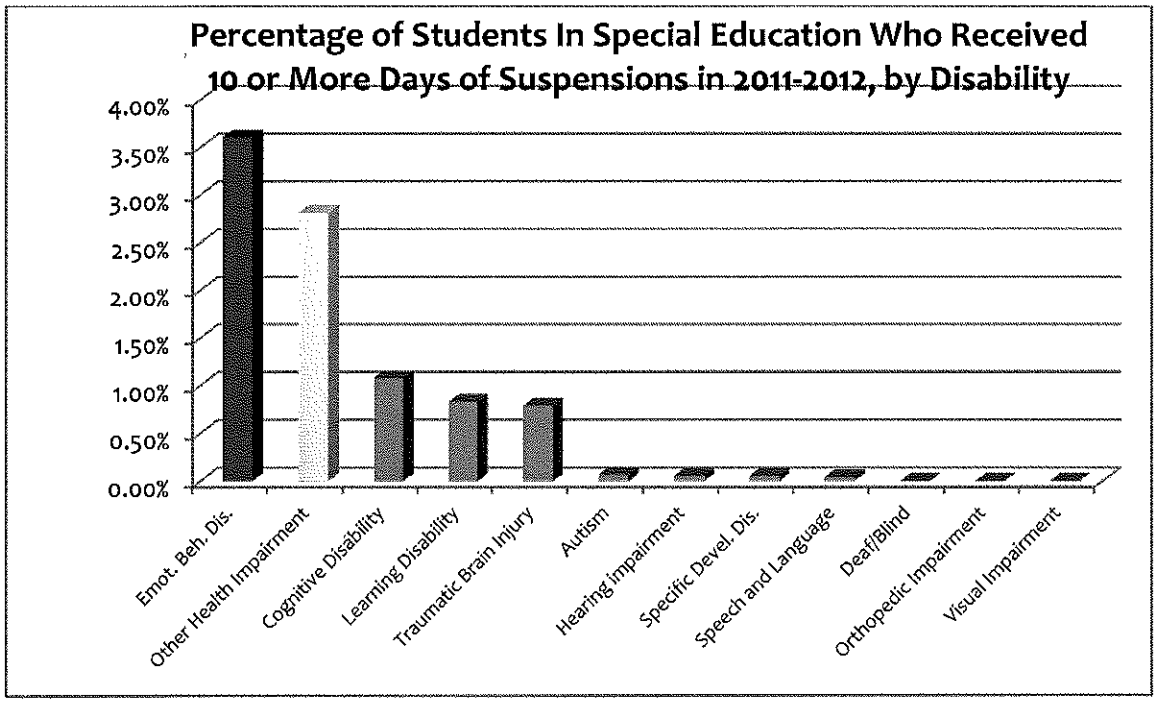
[79] Source: Individual Student Enrollment System (ISES).

Figure 9



By comparison, students with an EBD designation are 4.3 times more likely to receive extended suspensions and expulsions than children with learning disabilities and 52 times more likely than students with autism. In addition, there is the potential for children with behavioral and mental health issues to receive an "Other Health Impairment" (OHI) designation. This category includes children with only medical issues but also explicitly includes children diagnosed with Post Traumatic Stress Disorder and attention-based issues such as Attention Deficit Disorder. It is therefore notable that the second highest suspension category also includes children with social, emotional and behavioral challenges. (See Figure 10)

Figure 10

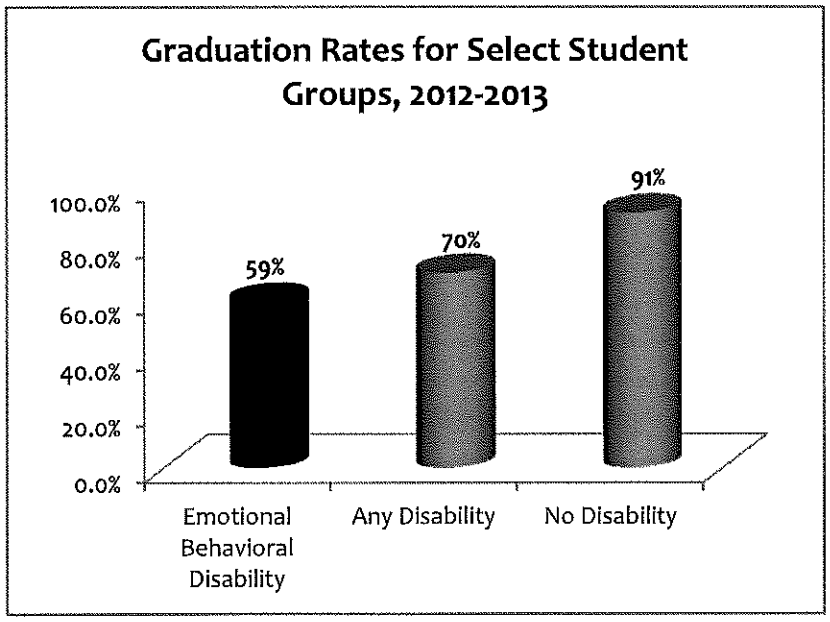


- **Early Education Expulsions:** Expulsions can and do occur before children enter elementary school. According to national research, for every 1,000 preschoolers enrolled in state pre-Kindergarten programs, 6.67 are expelled, compared with 2.09 per 1,000 students in K- 12 schools.[80] A 2010 Wisconsin study revealed that more than half of care providers had, during their careers, expelled infants or preschoolers from their care with the leading reason being behavioral issues.[81]

- **Seclusion and/or Restraint:** A central concern for parents and schools is the use of seclusion and/or restraint. While educators may deploy such measures with the intention of keeping staff and students safe, seclusion and/or restraint runs the risk of injuring the student and staff person as well as traumatizing the affected student, staff and student witnesses. A recent report by advocacy groups showed that such measures are used more frequently (74% of incidents) with students with disabilities and that the same students are repeatedly subjected to these measures. For instance, there were 21,454 reported incidents of seclusion and/or restraint during the 2012-13 school year, involving 2,976 students. This breaks down to an average of 7.2 experiences of seclusion and/or restraint per student.[82]

Low Graduation Rates: These and other difficult school experiences may help to explain the relatively low graduation rate for students labeled with Emotional Behavioral Disability (EBD). In recent years, approximately 57% of students with an EBD label have graduated within four years. This is comparable to graduation rates among students with autism and is ten percentage points below all students with disabilities while landing more than thirty percentage points below students without disabilities.[83] (See Figure 11)

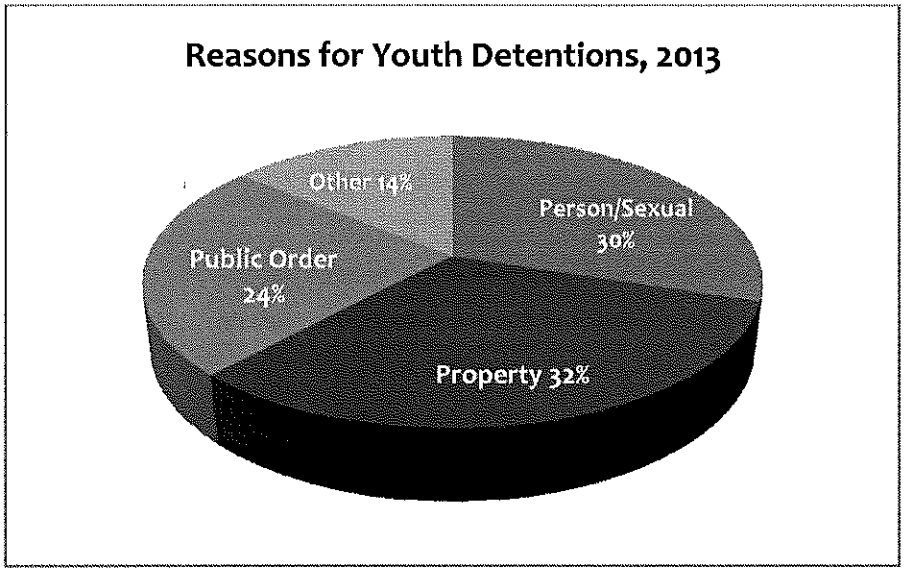
Figure 11



[80] Jacobson, L. 2005. "Preschoolers Expelled From School At Rates Exceeding that of K-12," Education Week.
[81] Supporting Families Together Association, "Child Retention in Wisconsin Child Care Settings: Understanding the Attitudes, Beliefs and Behaviors that Impact Expulsion and Retention in Early Care and Education," 2010.
[82] Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS, "Seclusion & Restraint in Wisconsin Public School Districts: 2012-2013 School Year Data."
[83] DPI graduation data prepared for this report. The average graduation rate from 2009-2012 for students with EBD is 58.0%, vs. 57.1% for students with autism, 68.2% for all students with disabilities, and 90.3% for all students without disabilities.

Juvenile Detention and Juvenile Corrections: In 2013, there were 7,829 detentions of juveniles, ages ten to sixteen.[84] This includes detentions within the fifteen[85] county detention centers and commitments to the two state (DOC) juvenile correctional institutions.[86] This amounts to approximately 15 detentions per 1,000 youth. Available data suggests that many youth are detained multiple times whether for technical violations or commission of a new offense. For instance, nearly half (48%) of Dane County's detentions in 2013 were readmissions of youth previously admitted that year.[87] Similarly, nearly two-thirds of young men (63.5%) and one-third of young women (32%) at the DOC's juvenile correctional institutions recidivated within three years of release.[88] Also of note is the fact that the majority of youth (70%) are detained for things other than crimes against people;[89] the greatest arrest category being "society" offenses, which include disorderly conduct, loitering, vagrancy and running away.[90] (See Figure 12)

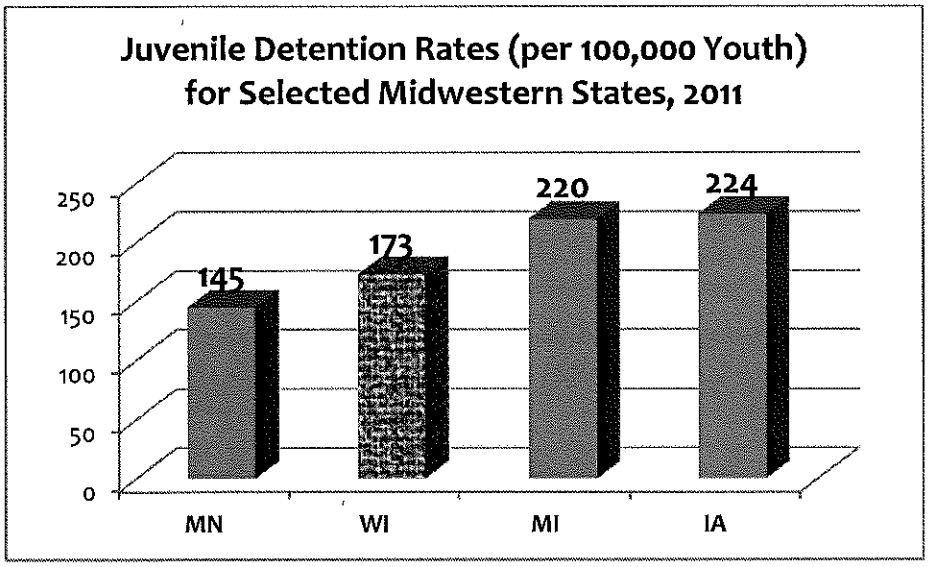
Figure 12



[84] Office of Detention Facilities 2013 Annual Report, p. 12.
[85] Two county detention facilities closed in 2013 bringing the current number of facilities to 13.
[86] DOC's Division of Juvenile Corrections uses the term "commitment" for youth detained in the two state juvenile correction institutions. This is not to be confused with psychiatric commitments or Emergency Detentions in psychiatric hospitals.
[87] Based on 2013 data supplied by Dane County Juvenile Court Program. Most of these readmissions were based on technical violations or missed court dates rather than new offenses. It is possible that other counties have either higher or lower readmission rates than Dane County; however, statewide data on the number of unduplicated youth detained was not available at the time of this report.
[88] DOC, Division of Juvenile Corrections 2013 Report, p. 4. Based on the 2009 cohort. The recidivism rate reflects the commission of new offenses rather than technical violations. It should be noted that DOC calculates recidivism over a longer period of time than many other states, which might make this number appear higher than that of some other states.
[89] Calculated based on data from the Juvenile Secure Detention Registry. See also Wisconsin Council on Children & Families Detention Data Report 2013.
[90] Query using Wisconsin Justice Data Portal examining statewide juvenile arrests for 2012.

Despite this fact, there are signs that Wisconsin is reducing juvenile detentions. Between 2001-2011 the state cut the number of youth detentions by 53%.[91] In addition, Wisconsin's juvenile detention rate is relatively low compared to neighboring states.[92] (See Figure 12)

Figure 13



As described in the section on "Prevalence," a high proportion of youth in detention have mental health issues and underlying trauma histories. Point-in-time data (2013) indicates that nearly all of the girls at Copper Lake School (94.3%) and four out of five boys at Lincoln Hills School (81.8%) were receiving mental health services.[93]

Racial Disparities: One theme that emerges across systems is that not all of Wisconsin's children and youth are at equal risk of experiencing mental health challenges, nor are they all equally supported by our state systems. For example:

- **Mental Health:** National data shows that racial and ethnic minority children have high rates of unmet mental health needs.[94] Black children have higher rates of behavioral health concerns than their White counterparts,[95] but Black children's behavioral challenges are more likely to be

[91] National Juvenile Justice Network and Texas Public Policy Foundation, "The Comeback and Coming-from-Behind States: An Update on Youth Incarceration in the United States." For more detail, see WCCF, "The Continuing State of Juvenile Justice in Wisconsin: Trends in Juvenile Delinquency in the 2000s."

[92] Calculations based on the 2011 Census of Juveniles in Residential Placement (for number of detentions) and Annie E. Casey Kids Count data center for 2011 figures of total number of youth. Michigan is similar to Wisconsin in capping the juvenile system at age 16; Iowa and Minnesota cap at 17. Information on other states was not available at the time of this report.

[93] DOC data query prepared for this report.

[94] Children's Defense Fund, "Mental Health Fact Sheet," 2010.

[95] SAMHSA. *Mental Health, United States, 2010.* Percentage of persons aged 4 to 17 with reported emotional and behavioral difficulties by level of severity and selected characteristics, 2009. Black rates of severe difficulties are 1.5% higher than white; rates of minor difficulties are 3.7% higher (both races non-Hispanic).

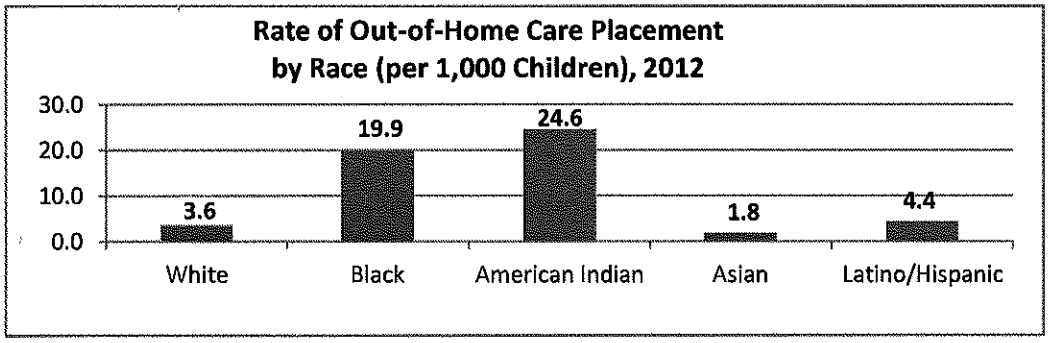
routed to the juvenile justice system than the mental health system.[96] Nationally nearly nine out of ten Latina/o youth (88%) with mental health needs do not receive services.[97]

- **Toxic Stress:** Surveys of Wisconsin adults show that Black Wisconsin residents are more likely than their White counterparts to have experienced ACEs.[98] Presumably today's children are also experiencing differential exposure by race.

- **Suicidality:** Students of color were at increased risk of attempting suicide. Hispanic or Latino students were 2.6 times more likely than their white peers to report that they attempted suicide.[99] Black students were close to four times more likely than White students to attempt suicide (16.2% versus 4.3%) and one in six Black high school respondents (16.2%) reported that they had attempted suicide in the past year.[100] This makes Wisconsin's Black suicide attempt rate 82% higher than the national average (16.2% versus 8.8%).[101]

- **Child Welfare:** Wisconsin's minority children are over-represented in foster care and residential facilities. While the majority of these children are White (55% in 2012), White children are under-represented in the system relative to their proportion in the state overall. Race-specific rates of out-of-home care show that American Indian children are at the highest risk of being placed in foster care (24.6 per 1,000 children) and are almost seven times more likely to be in out-of-home care than their White peers (24.6 versus 3.6 per 1,000). Black children are also placed out-of-home at high rates; at almost 20 children/youth placed per 1,000, they are more than six times more likely to be placed outside the home than their white peers.[102] (See Figure 14)

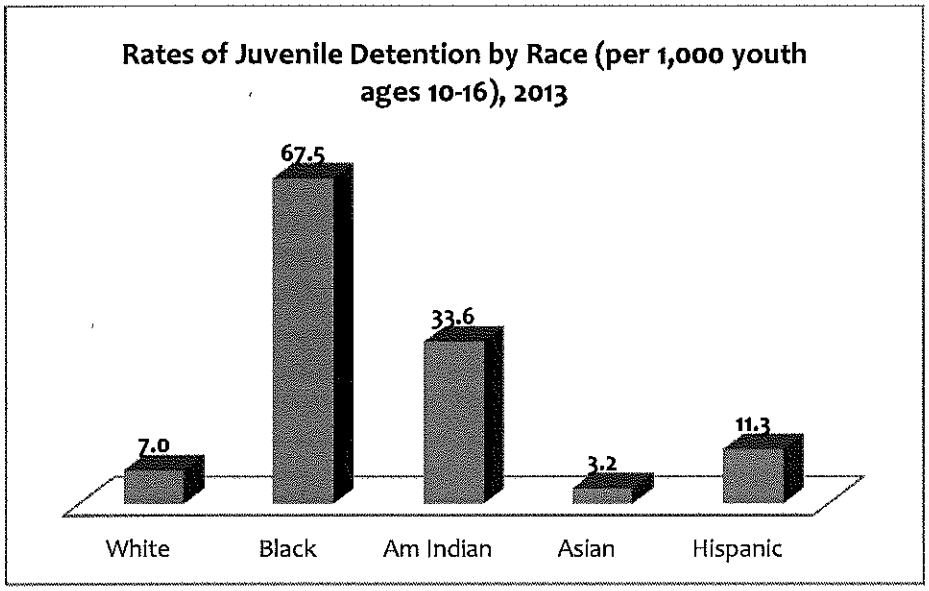
Figure 14



[96] The Children's Defense Fund Mental Health Fact Sheet, March 2010.
[97] Ibid.
[98] Children's Trust Fund and Children's Hospital of Wisconsin, "Wisconsin ACE Brief: 2011 and 2012 Data", p. 3-4.
[99] 11.3% vs. 4.3% in 2013 YRBS. Differences are statistically significant. Both Black and Hispanic/Latino youth were also more likely to report that their attempts led to injuries treated in the hospital.
[100] CDC Youth Online High School YRBS results.
[101] YRBS data comparing Wisconsin to national average. 2013. Available at CDC Youth Online YRBS. The difference is statistically significant (p=0.05) as is the difference in black suicide attempts resulting in injuries (8.0% WI vs. 2.7% nationally).
[102] Placement data based on unduplicated child counts, DCF's 2012, "Annual Report on Out-of-Home Care." Overall number of children in each racial group based on 2012 Wisconsin figures from Annie E. Casey Kids Count Data Center.

- **Juvenile Detention and Arrest:** While Wisconsin's population remains overwhelmingly White and non-Hispanic, the majority (60%) of juvenile detentions in 2013 were youth of color. Overall, almost half of the juvenile detentions in 2013 (47%) were Black youth. There are more pronounced differences when we look at the race-specific rates of detentions (i.e., number of detentions of White youth/age-adjusted number of White youth in Wisconsin): the juvenile detention rate for Wisconsin's White youth is 7.0 per 1,000 youth (ages 10-16),[103] whereas for American Indians it is 33.6 per 1,000 and for Black youth it is 67.5 per 1,000.[104] (See Figure 15)

Figure 15

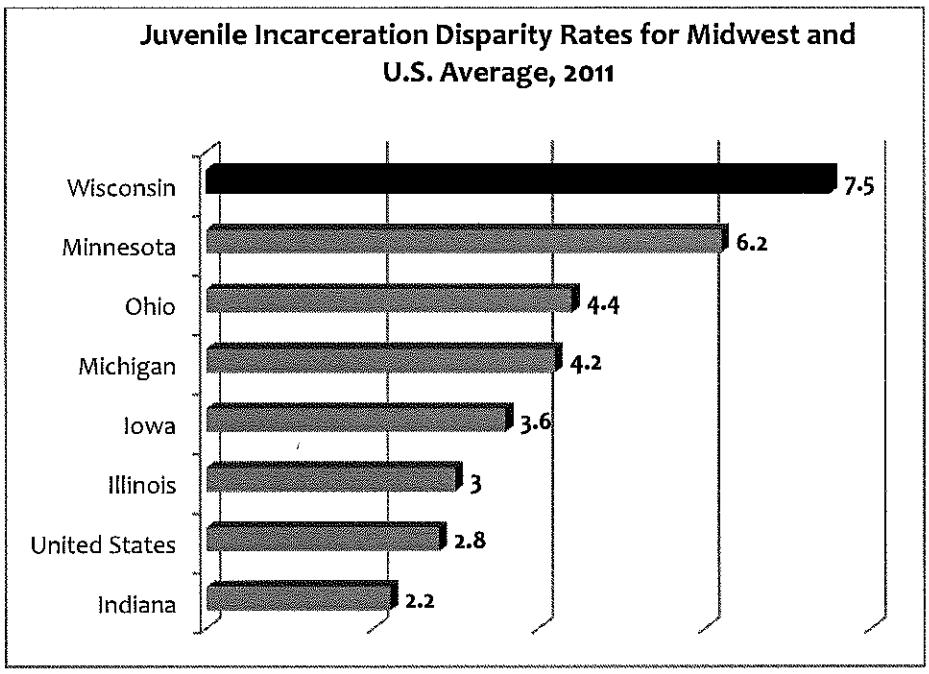


When comparing disparities in arrests that lead to detentions, it is evident that racial disparities become larger the farther along one moves into the juvenile corrections system. For instance, Wisconsin Black youth are approximately four times more likely to be arrested than White youth,[105] yet the detention rates outlined above show that they are nearly ten times more likely than White youth to be detained (67.5 vs. 7.0 per 1,000, or 9.6 times).[106] At the most secure facilities (DOC's two juvenile institutions) almost seven out of ten young people were Black.[107] It can be assumed that once arrested, White youth are more likely to be filtered out of the juvenile

[103] In Wisconsin youth can be detained or committed in the juvenile system if they are 10-16 years old.
[104] These detention rates are based on the number of detentions, not the unduplicated number of youth detained which were unavailable at the time of publication. The rates were calculated based on all 10 to 16 year olds in each racial or ethnic category in 2013. Source: National Center for Health Statistics Vintage 2013 Bridged-Race Postcensal Population Estimates. Racial/ethnic categories are based on those used by the Juvenile Secure Detention Registry. All categories except "Hispanic" are presumed to be non-Hispanic in ethnicity.
[105] Lecoanet et al., "Disproportionate Minority Contact in Wisconsin's Juvenile Justice System." UW Population Health Institute, September 2014.
[106] Based on the total number of admissions to county detention centers and DJC facilities in 2013. Source: Juvenile Secure Detention Registry.
[107] 69% of newly committed juveniles at Lincoln Hills and Copper Lake in 2013. Source: Division of Juvenile Corrections 2013 Annual Report, p. 3.

corrections system, while Black and American Indian youth are more likely to be filtered in.[108] This mirrors disparities in Wisconsin's adult correctional system and, in line with Wisconsin's adult correctional population, national data shows that Wisconsin's disparities for juvenile justice are the worst in the nation.[109] (See Figure 16)

Figure 16



- **School Suspensions:** Looking generally at school suspensions without regard to disability status, more than one in five Black students were suspended in 2013 (21.32%). This was more than nine times the suspension rate for their White peers (2.26%). (Nationally the disparity is three times higher.)[110] American Indian students were suspended at just over three times the rate of White students (7.09%) and Hispanic/Latino students were twice as likely as their non-Hispanic White peers to be suspended (4.89%).[111]

[108] This is in line with national inequities. See e.g. NAACP Criminal Justice Fact Sheet. One question that arises is whether this difference can be explained based on the severity of the offense. Raw data is not currently available to perform this analysis. However, a strong research literature on adult corrections consistently shows differences in sentencing across racial lines. See e.g. The Sentencing Project "Racial Disparity in Sentencing: A Review of the Literature," January 2005.
[109] The W. Haywood Burns Institute for Juvenile Justice Fairness & Equity. "Unbalanced Juvenile Justice". Map available at http://data.burnsinstitute.org/#comparison=2&placement=1&races=2,3,4,5,6&offenses=5,2,8,1,9,11,10&year=2011&view=map. Based on 2011 data.
[110] U.S. Dept. of Education Office for Civil Rights, "Data Snapshot: School Discipline." Issue Brief No. 1, March 2014.
[111] DPI WiseDash online data dashboard. "What percentage of students were suspended or expelled?" View by Race/Ethnicity.

INDICATORS OF SYSTEM IMPROVEMENT

While this information is a clear call to action, there are also reasons for hope. Across Wisconsin, there are many emerging positive trends that include the following:

- Expansion of the number of Coordinated Service Teams (CST) and Comprehensive Community Services (CCS) available to children with mental health challenges,
- Low levels of repeat maltreatment for families who come to the attention of the child welfare system,[112]
- Declining levels of depression and suicide attempts among high school students,[113]
- Reductions in the number of children suspended or expelled from school,[114]
- Wisconsin's dropout rate for students with disabilities is approximately half the rate for other states making Wisconsin the 10th lowest dropout rate of the 43 states reporting,[115]
- Reductions in the rates of juvenile arrests and detentions.[116]

In addition, we see many other promising developments, such as:

- DHS's expansion of CCS will increase access to supportive services that may lead to reduced hospitalizations,
- DPI's efforts to re-shape the school environment through interventions such as Positive Behavioral Interventions and Support (PBIS) and Response to Intervention (RTI) may reduce the use of seclusion and restraint and expulsions,
- DOC/DJC, along with their county partners, have been nationally recognized for enacting policies that have reduced youth detentions without prompting an increase in youth crime; [117] DOC/DJC has also created an innovative residential facility called the GROW Academy,
- DCF has set performance goals to help reduce out-of-home care and improve other outcomes for children at risk,
- DHS/DCF jointly established a specialized medical program, Care4Kids, to provide comprehensive physical, behavioral, and dental health services to foster children in ways that meet their unique needs and to recognize the trauma they have experienced.

Another sign of hope is the growing recognition that early childhood relationships and experiences matter. Examples include the Family Foundations Home Visiting Program, the Pyramid Model for Social and Emotional Competence, University of Wisconsin's Infant Mental Health certification, YoungStar, statewide 4K, Wisconsin Healthiest Family Initiative and the 2014 Legislative Council Steering Committee for Supporting Healthy Early Brain Development.

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[112] DCF, "Kidstat Performance Report: January-June 2014," p.12.
[113] DPI, 2013 YRBS Executive Summary, p. 5. Examines trends from 1993-2013.
[114] Wisconsin DPI WiseDash.
[115] Wisconsin and 42 other states similarly calculated dropout rates. Wisconsin's dropout rate for students with disabilities was 2.46%, vs. a mean of 5.7% and a median of 4.4% for states reporting this calculation. National Dropout Prevention Center for Students with Disabilities, "An Analysis of States' FFY 2011 Annual Performance Report Data for Indicator B2 (Dropout)." Prepared for the U.S. Department of Education Office of Special Education Programs, July 2013, p.3.
[116] WCCF, "The Continuing State of Juvenile Justice in Wisconsin: Trends in Juvenile Delinquency in the 2000s."
[117] The National Juvenile Justice Network and Texas Public Policy Foundation. "The Comeback and Coming-From Behind States: An Update on Youth Incarceration in the United States," n.d.

Emerging Issues

While the Common Agenda (See Collective Impact, p. 12) will provide OCMH's primary focus over the next year, several issues have emerged that will be included in the OCMH's list of partnership activities.

SCHOOL-BASED MENTAL HEALTH

School-based mental health is viewed by many as a solution to many of the barriers facing children and families seeking mental health services. As of July 2014, 57 school districts (out of 424) had satellite clinics and 40 additional organizations had applied for DHS certification. Because successful implementation of this model is contingent on the supportive qualities of the school culture, advocates stress the need for a tandem approach by strengthening Tier One and Tier Two of Positive Behavior Intervention and Supports[118] and increasing the schools' commitment to trauma sensitivity.[119]

Currently, the Safe Schools/Healthy Students state management team and several other coalitions are working to develop a statewide infrastructure for the promotion and support of school-based mental health. Discussion among these groups and other interested parties include the challenges of finding funding for crucial teacher / parent consultation to ensure that skill development is reinforced in home and classroom environments; as well as the need for connection with community services and other psychosocial rehabilitative services.

PARENT PEER SPECIALISTS

For years, DHS/DMHSAS has promoted using "peer specialists" an evidence-based practice and a key piece of a recovery-oriented mental health system. More recently, DMHSAS has initiated the development of a statewide infrastructure to certify Parent Peer Specialists (PPSs).

PPSs are parents or caregivers of children with mental, emotional, or behavioral issues specifically trained to assist other parents by providing information, resources and support. In other states, PPSs work in a variety of settings, including family network organizations, crisis stabilization units, schools, social services agencies, and other mental health settings. Reported outcomes include parents who feel less alone, are able to see hope for the future, see family strengths and experience an increase in their ability to deal with stress.[120] DHS also plans to further develop the state's certification and support infrastructure for youth (ages 18-26) wishing to serve as Peer Specialists.

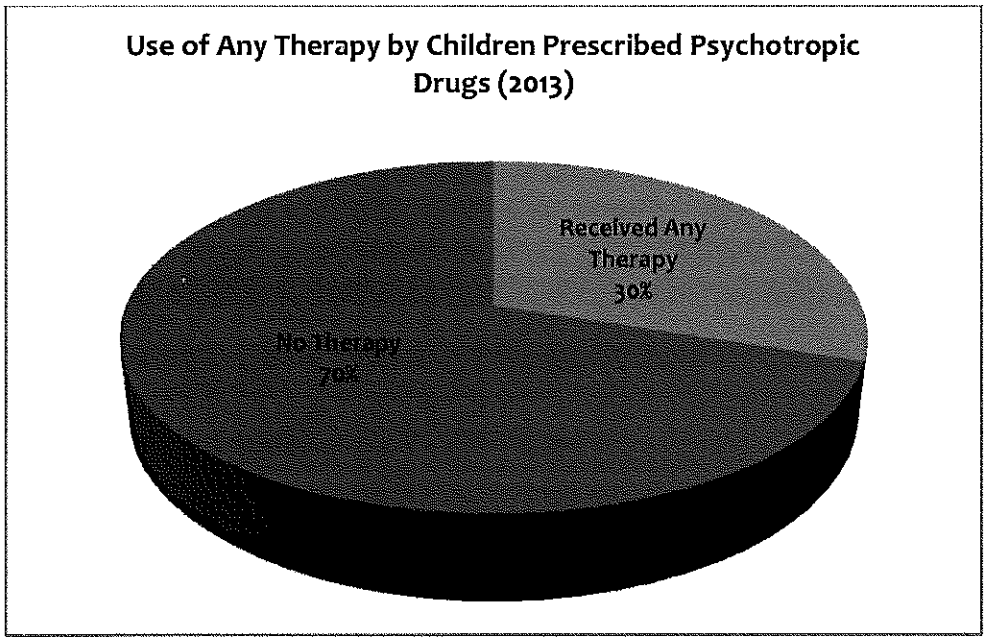
[118] http://rti.dpi.wi.gov/rti_pbis.
[119] http://sspw.dpi.wi.gov/sspw_mhtrauma.
[120] Centers for Medicare & Medicaid Services Memo, August 15, 2007.

PSYCHOTROPIC MEDICATION

Nationally, between 1998 and 2008, the number of people under age 20 receiving Medicaid-funded prescriptions for antipsychotic drugs tripled, while children on Medicaid were prescribed antipsychotics at four times the rate of privately insured children.[121]

The Centers for Medicare and Medicaid Services has encouraged the reduction of the use of antipsychotics and encouraged doctors to consider alternative treatment approaches such as trauma-specific therapy.[122] DHS and DCF have taken important steps in understanding the extent of this issue in Wisconsin, including interviewing mental health providers about their prescribing practices, reviewing current prescribing recommendations and best practices, and analyzing state data to understand prescribing practices for children in out-of-home care. One early finding is that only 30% of the nearly 70,000 Wisconsin children in Medicaid who are prescribed these drugs receive therapy.[123]

Figure 17

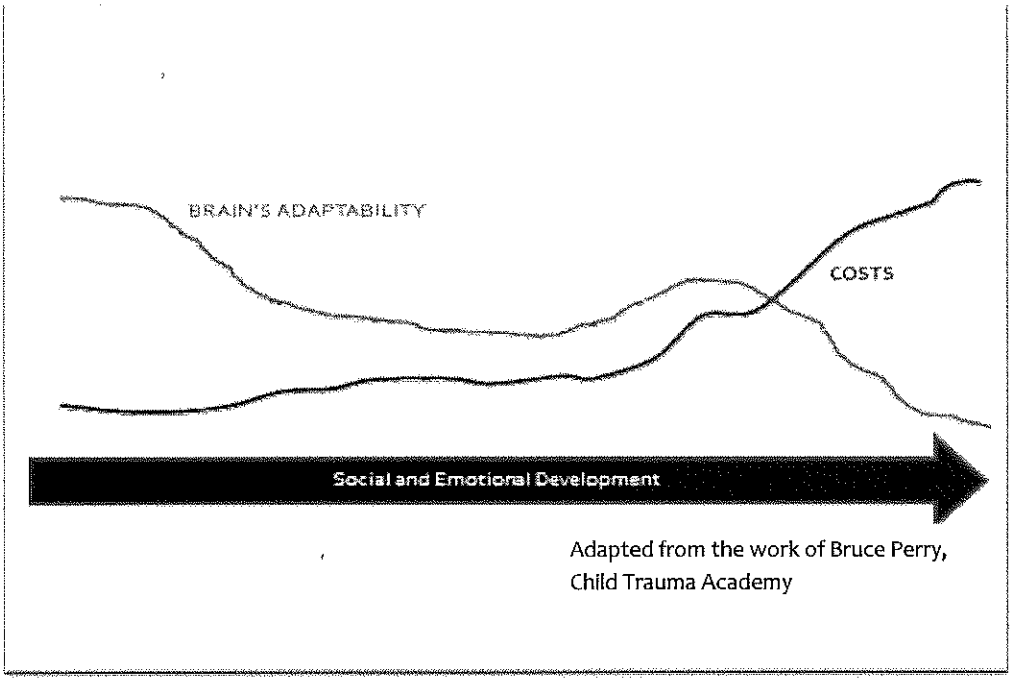


[121] *The Wall Street Journal*, August 2013, US Probes Use of Antipsychotic Drugs on Children.
[122] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16 State Study. MMDLN/Rutgers CERTs Publication #1. July 2010.
[123] Analysis of 2013 Medicaid data conducted by DHS's Office of Health Informatics. Excludes children who were only prescribed stimulants.

YOUTH PSYCHIATRIC HOSPITALIZATION

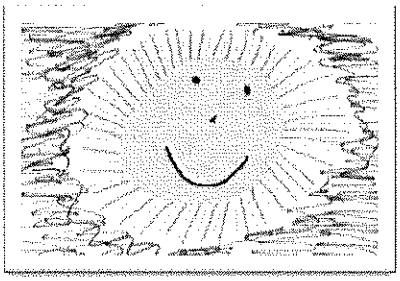
While our service landscape shows that Wisconsin has a variety of programs geared towards prevention and early intervention, there is still a need to intervene earlier to reduce the use of hospitals, foster care, and juvenile detention. This strategy not only prevents hardship but also promises a reduction in costs over the course of a lifetime (See Figure 18).

Figure 18



DHS recently convened a workgroup including the OCMH, DCF, provider organizations and county representatives to examine the high rate of youth psychiatric hospitalizations and make recommendations about how best to intervene earlier to reduce admissions. Additionally, DHS recently awarded a second set of five-year county crisis intervention grants with an emphasis on serving youth. OCMH will work with these and other partners to continue to address this issue in 2015.

Next Steps



The OCMH 2015 agenda includes the following:

INNOVATE

- Support state agencies in incorporating the voices of lived experience in policy development and systems' change initiatives.
- Promote greater understanding among stakeholders of the role of adversity and toxic stress in understanding social and emotional development.

INTEGRATE

Within the context of Collective Impact...

- Create a common agenda for systems change across state agencies.
- Identify shared measures of system performance to track progress towards the common agenda.
- Establish plans for data standardization and integration to better understand service availability and outcomes.

IMPROVE

- Identify the factors underlying Wisconsin's high rates of youth psychiatric hospitalizations and bring stakeholders together who can help propose solutions.
- Develop an understanding of mental health services within counties and tribes.
- Begin cross-system action steps to address racial disproportionality.
- Inform legislators of the strengths, weaknesses, opportunities and impediments to system improvement.

Conclusion

Much of the information in this report is not new. NAMI last graded states in 2009, at which time Wisconsin received a "C" overall and "D"s in both Health Promotion and Measurement and Community Integration and Social Inclusion while doing better ("B") in Financing and Core Treatment and Recovery Services. The good news is that since that time, Wisconsin has established more services for both adults and children.

In 2009, a report authored by Disability Rights Wisconsin, Wisconsin FACETS and Wisconsin Family Ties[124] exposed the problem of seclusion and/or restraint of children in schools, residential treatment facilities, and hospitals. This joint report spurred legislation requiring the documentation of these practices. Other recommendations made in the report, such as making schools more trauma-informed and making greater use of Positive Behavioral Interventions and Supports, are currently underway in much of the state.

In 2012 the Johnson Foundation brought to light the relatively low rate of Wisconsin's children's public mental health services, the high rates of suspensions and drop-outs for children with mental health issues, and the overall social costs of non-treatment or insufficient treatment.[125] That report recommended more emphasis on prevention and early intervention, as well as expanded treatment options.

The OCMH believes that the collective understanding of the challenges facing Wisconsin's children and families has reached a tipping point. Let this report serve as one of the many sparks leading to a 'wildfire' representing our children's brighter future.

> *"The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire."*
>
> *Malcolm Gladwell, author of The Tipping Point*

[124] "Out of Darkness Into the Light: New Approaches to Reducing the Use of Seclusion and Restraint with Wisconsin Children," Spring 2009.
[125] The Johnson Foundation at Wingspread. "Top of Mind: Children's Mental Health in Racine."

Appendices

APPENDIX A: 2013 WISCONSIN DEMOGRAPHICS

Race and Ethnicity: Data is based on all children or youth under age 18. Source is the Annie E. Casey Kids Count Data Center (based on the U.S. Census). All categories are non-Hispanic in ethnicity, unless otherwise noted.

2013 Child Population By Race		
Race/Ethnicity	**Number**	**Percentage**
White	946,337	72%
Black	112,999	9%
American Indian	13,898	1%
Asian American	42,895	3%
Native Hawaiian and Other Pacific Islander	417	<0%
Two or more races	46,722	4%
Hispanic or Latino	144,508	11%
Total < 18	1,307,776	100%

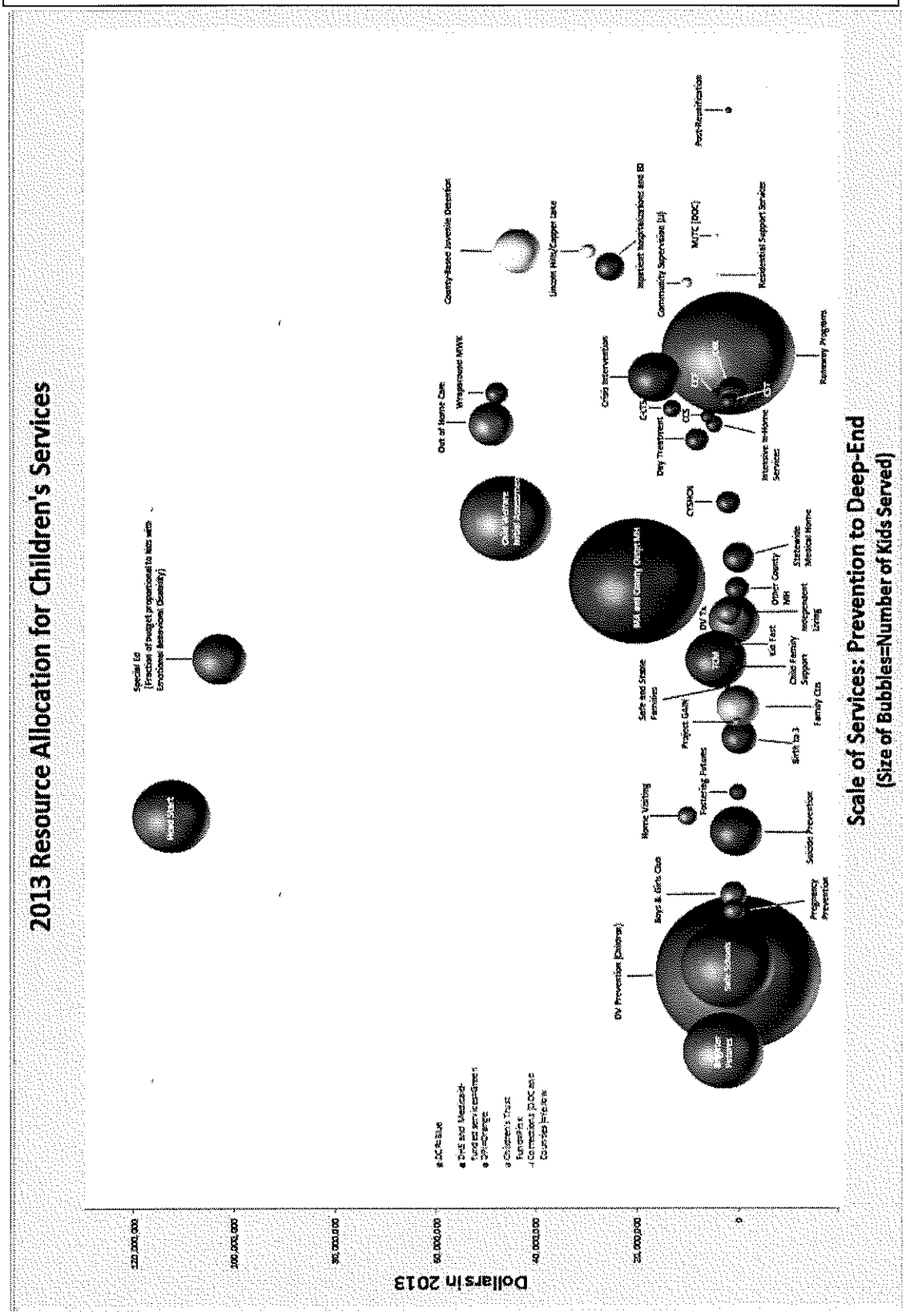
Age: From 2013 U.S. Census Bureau Figures

- 22.8% of the state is under 18 (versus 23.3% nationally)
- 6.0% of the state is under 5 (versus 6.3% nationally)

Tribal Data: One notable absence from this report is missing data related to the social and emotional health of Native American children. The current report is based on data submitted to the state by counties. Due to their status as sovereign nations, tribes have a separate reporting process. The OCMH is aware that, due to recent and historical misuse of data, data collection and reporting is a sensitive issue for many tribes. In the future, the OCMH will strive for ways to represent the experiences of tribal children and youth while respecting tribes' preferences with regard to data reporting.

Appendix B: Wisconsin Child Service Landscape.

Larger copy available upon request: Katherine.McCoy@dhs.wisconsin.gov



Glossary

ACEs or Adverse Childhood Experiences are some of the most intensive and frequently occurring sources of stress that children may suffer early in life. These experiences include physical, sexual and emotional abuse; neglect; violence between parents of caregivers; alcohol and substance abuse; mental health issues for caregivers; incarceration of a household member; divorce; and peer and community violence.

ACE Interface is a company dedicated to disseminating educational products, providing consultation about ACEs, developmental neurobiology, resilience and community empowerment.

Alianza Latina Aplicando Soluciones (ALAS) is a non-profit organization providing educational workshops, parent support groups, family events, community building activities, and service referrals for families with children and youth with diverse abilities in Wisconsin.

Behavioral Risk Factor Survey is an annual telephone survey of state residents 18 and older that collects data on behavioral health risk factors associated with the leading causes of premature mortality and morbidity among adults. This survey is carried out in conjunction with the U.S. Centers for Disease Control and Prevention (CDC). **Youth Risk Behavior Survey** is an epidemiologic survey system established by CDC to monitor the prevalence of youth behavior that most influences health. Youth Risk Behavior Survey monitors six types of health risk behaviors that contribute to the leading cause of death and disability among youth and adults. The behaviors monitored include weapons and violence; suicide; tobacco use; alcohol and other drug use; traffic safety; sexual behavior; diet; nutrition; and exercise. The survey is administered to high school students in the public school system.

Children refer to individuals under the age of 18 years.

Comprehensive Community Services (CCS) is a locally administered Medicaid program for persons with mental health and/or substance-use disorders that provide a flexible array of individualized, community-based, psychosocial rehabilitation services.

Coordinated Services Teams (CST) are wraparound models of care for children with behavioral health issues. The model is targeted to children and families involved in two or more systems of care who have complex needs.

DCF is the Wisconsin Department of Children and Families.

DHS is the Wisconsin Department of Health Services.

Disproportionality is the overrepresentation of a group of people in a program or system.

DOC is the Wisconsin Department of Corrections.

DPI is the Wisconsin Department of Public Instruction (Education).

Emotional Behavioral Disability (EBD) is an official designation used by schools for children with mental, emotional, social, and behavioral challenges.

Family Foundations Home Visiting Program is a joint effort between DCF and DHS aimed at improving outcomes for children born into at-risk communities and reducing incidents of child maltreatment through evidence based home visiting programs. It is currently available in 15 counties and four tribal communities.

Fostering Futures is a project aimed at developing a statewide, interdisciplinary approach to integrate evidence about adverse childhood experiences and the benefit of resiliency and trauma-informed care into the state and local systems of care that impact Wisconsin children and families, especially those involved in the child welfare system.

4 year old kindergarten (4K) is a kindergarten program for children who have reached the age of 4 by September 1. Wisconsin is a leading state in the provision of universally available four-year-old kindergarten programs. Of the 424 school districts in the state, 386 offered 4 year old kindergarten in the 2013- 2014 school year.

IEP is an individualized education plan. Such plans are required for children in Special Education. Therefore, noting that a child has an IEP implies that she or he is engaged in Special Education services.

Mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[126]

Mental health recovery model emphasizes recovery as a personal journey rather than a set outcome. It may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning.

National Alliance on Mental Illness (NAMI) is an organization dedicated to promoting recovery and improving the quality of life of people and families affected by mental health challenges.

Neurological architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Early experiences literally shape how the brain is built; a strong foundation in the early years increases the probability of positive outcomes, while a weak foundation increases the odds of later difficulties

Parent Peer Specialist (PPS) is a parent or caregiver of children with mental, emotional, or behavioral issues specifically trained to support other parents by providing information, resources and support.

[126] World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2001.

Positive Behavioral Intervention and Supports (PBIS) is a systemic approach to proactive, school-wide behavior based on teaching what behaviors are expected, practicing those behaviors and providing positive reinforcement when the behaviors are displayed.

Public health is the science of taking a population-based approach to preventing disease and promoting health. This model considers human factors, characteristics of the source of harm, and the environment, identifying causes and suggesting possible ways to intervene.

Pyramid Model for Social and Emotional Competence is a framework that promotes healthy social and emotional development in child care settings by creating engaging environments, providing concrete teaching strategies, and if/when needed creating individualized interventions for children.

Resilience is the ability to bounce back despite challenging or threatening circumstances.[127]

Severe Emotional Disturbance (SED) is a mental health challenge that severely disrupts a child's or adolescent's daily life and functioning at home, at school, or in the community.

Social and emotional wellbeing are those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways. It includes how children engage in relationships, cope with challenges, handle responsibilities, and manage and express emotions.

Stakeholders are partners or collaborators that have an interest or investment in a common goal.

State agencies are Wisconsin agencies with a statewide presence. Those frequently referenced in this report include the Department of Health Services (DHS), the Department of Children and Families (DCF), the Department of Public Instruction (DPI) and the Department of Corrections (DOC).

Stress (Positive, Tolerable and Toxic) Positive stress is moderate and short-lived increase in heart rate or mild changes in stress hormones that occur in the context of stable and supportive relationships. Positive stress is regarded as an important and necessary aspect of healthy development. Tolerable stress is severe enough to disrupt brain architecture if unchecked, but is frequently buffered by supportive relationships that facilitate adaptive coping and mitigate the damaging effects. Toxic stress is caused by exposure to excessive adversity such as abuse, neglect, or exposure to violence and instability. Toxic stress leads to "strong, unrelieved activation of the body's stress management system" and raises the risk of a host of physical and mental health problems.[128]

Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads efforts to reduce the impact of substance abuse and mental health concerns on communities.

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[127] The Children's Charity, "Literature Review: Resilience in Children and Young People. June 2007.
[128] Center for the Developing Child, Harvard.

Trauma-informed care is a framework which integrates knowledge about the prevalence and impact of adversity, toxic stress and trauma in reshaping interpersonal interactions, organizational operations and community activities.

Trauma Project is an initiative led by DCF that trains mental health therapists in Trauma Focused-Cognitive Behavioral therapy, provides a 16 hour workshop for parents, resource parents, child welfare workers and juvenile justice workers in caring for children who have experienced trauma and community trainings on trauma-informed care.

University of Wisconsin's Infant, Early Childhood, and Family Mental Health Capstone Certificate Program is an intensive, interdisciplinary program for practicing professionals who work with families in the prenatal and postpartum periods and with children ages birth through five years. The program is informed by theory and current empirical knowledge from developmental, neuroscience and attachment research.

Wisconsin Council on Children and Families is a private, non-profit, non-partisan organization providing research, policy analysis, public education and advocacy on issues effecting children and their families in the areas of health, economic security, safety and education.

Wisconsin Family Assistance Center for Education, Training and Support (Wisconsin FACETS) is a statewide non-profit organization, dedicated to helping families understand the special education laws and systems.

Wisconsin Family Ties (WFT) is a family run, statewide, non-profit organization supporting families that include children and adolescents with social, emotional and behavioral challenges.

Wisconsin Healthiest Families Initiative (WHFI) focuses on networks of services addressing family supports, child development, mental health and safety and injury prevention. Local public health departments' work with community partners to build an integrated system that promotes optimal physical, social-emotional, and developmental health of children and their families.

Wraparound is a nationally recognized approach to mental health service delivery that seeks to bring different systems involved in a child's life to the table when planning and evaluating that child's services. In Wisconsin, the wraparound philosophy is at the heart of at least three programs: Wraparound Milwaukee, Children Come First (Dane County), and Coordinated Service Teams.

YoungStar is Wisconsin's child care quality rating and improvement system. YoungStar sets a rating from one to five stars based on education, learning environment, business practices and the well-being of children.