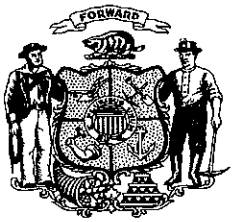
STATE OF WISCONSIN

SENATE CHAIR
Alberta Darling

317 East, State Capitol
P.O. Box 7882
Madison, WI 53707-7882
Phone: (608) 266-5830



ASSEMBLY CHAIR
John Nygren

309 East, State Capitol
P.O. Box 8953
Madison, WI 53708-8953
Phone: (608) 266-2343

JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative John Nygren

Date: December 20, 2017

Re: WOCMH Report to JFC

Attached is the 2017 Wisconsin's Office of Children's Mental Health report to JFC, pursuant to s. 51.025(2), Stats.

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

AD:JN:jm

DEC 20 2017
J. Finance

State of Wisconsin

Scott Walker, Governor
Elizabeth Hudson, Director

December 19, 2017

Governor Scott Walker
State Capitol

Senate President Roger Roth
220 South, State Capitol

Speaker Robin Vos
217 West, State Capitol

Dear Governor Walker, President Roth, and Speaker Vos:

I am pleased to present the ***Wisconsin's Office of Children's Mental Health 2017 Report to the Legislature*** as required in s. 51.025(2), Wis. Stats.

The Wisconsin Office of Children's Mental Health (OCMH) is tasked with tracking Wisconsin's children and family outcomes related to involvement in state sponsored programs, services, and supports. Because service data is not consistently available, the OCMH has focused on developing proxies to measure program success. Last year, the OCMH created and measured forty-eight child-well-being Wisconsin indicators and provided national comparisons. In this report, we updated the data and identified upward and downward trends in both Wisconsin and the U.S.

In this year's report, we have furthered our commitment to measuring child and family well-being by creating fifteen fact sheets highlighting data including Children's Medicaid Funded Mental Health Services, Crisis Intervention Services for Children on Medicaid, Mental Health Provider Availability, Opioid and Methamphetamine Use, Outpatient Mental Health Service Data for Children on Medicaid, Psychotropic Medication Prescribing for Children on Medicaid, Youth Psychiatric Hospitalizations, Readmissions, and Emergency Detentions, and Youth Suicide and Self Harm

Other significant activities highlighted in this year's report include staff's leadership and involvement in activities ranging from prevention to deep end intervention.

The OCMH staff looks forward to 2018 and our continued work with Wisconsin stakeholders. As always, please contact me if you have any questions.

Sincerely,

Elizabeth Hudson

Elizabeth Hudson, LCSW
Director, Office of Children's Mental Health
608-266-2771 (p)
Elizabeth.Hudson@wisconsin.gov

2017 REPORT TO THE WISCONSIN LEGISLATURE

TABLE OF CONTENTS

LETTER FROM THE DIRECTOR 1
EXECUTIVE SUMMARY 2
WISCONSIN OFFICE OF CHILDREN'S MENTAL HEALTH ACTIVITIES 6
CHILDREN'S MENTAL HEALTH COLLECTIVE IMPACT 17
WISCONSIN CHILD WELL-BEING INDICATORS (2017) 29
WISCONSIN CHILD WELL-BEING FACT SHEETS 33
MANY THANKS 68
APPENDIX 79

2017 Wisconsin Office of Children's Mental Health Staff and Interns

Kim Eithun-Harshner, Operations Lead
Elizabeth Hudson, Director
Tammi Kohlman, Medical College of WI Public Health Intern
Lynne Morgan, Research Analyst
Tiffany Raddatz, UW-Madison, Social Work Intern
Joann Stephens, Family Relations Coordinator

LETTER FROM THE DIRECTOR

Dear Friends,

Almost four years have passed since the Wisconsin Office of Children's Mental Health (OCMH) was created. We published our first report in 2014 outlining data related to children's involvement in the state's service systems and soon recognized that we had addressed an important need. As a result of stakeholder feedback, we made a commitment to revisit child and family data every three years. As such, this year's report provides information that creates a picture of the social and emotional well-being of Wisconsin's children and families.

For a variety of reasons, both national and Wisconsin child service outcomes are not well-documented. It is our hope that the data found in this report serves as a proxy for the effectiveness of Wisconsin's child and family policies and programs within service areas such as mental health, public schools, youth justice, and child welfare.

Numbers, graphs, and tables only tell part of the story. Also incorporated into the fact sheets are the reflections of Children's Mental Health Collective Impact parents and young adults. These leaders remind us that children and families' well-being is at imminent risk and our immediate attention is needed.

Looking into 2018, our office will invest in better understanding data from a systems' perspective – for example, if we identify a correlation in the reduction in juvenile detentions and an increase in crisis services and emergency detentions, will deeper analyses uncover that children are being re-directed from a more punitive system to more appropriate mental health services?

Additionally, we will continue supporting the Children's Mental Health Collective Impact with the following anticipated results:

- increased racial and ethnic diversity within the Collective Impact Partner group,
- accelerated statewide mapping of trauma-informed care (TIC) initiatives and continued TIC policy workshops,
- updated OCMH website leading to greater public awareness of and easier access to tools created within the collective impact workgroups, and
- improved access to mental health services through the development of a children's mental health "single point of entry" plan.

Another central activity in the coming year will include hiring a new Family Relations Coordinator. Joann Stephens, our first coordinator, provided expert leadership to the collective impact parents and young adults. Her work will continue at her new job with the Department of Health Services, while her legacy of family and youth-driven services will remain strong at the OCMH.

If you would like to learn more about our work, or have an interest in participating in children's mental health change efforts, please be in touch.

All the Best,

Elizabeth Hudson

EXECUTIVE SUMMARY

The Wisconsin Office of Children's Mental Health (OCMH) was created in the 2013-2015 biennial budget to support Wisconsin's children in achieving their optimal social and emotional well-being. Statutorily,[1] the OCMH is charged with the following:

- Improve children and families access to services, with a focus on resources provided by the Department of Children and Families, Department of Corrections, Department of Health Services, and Department of Public Instruction;
- Facilitate communication with all child and family-serving state agencies, coordinate initiatives, and monitor children's mental health service performance;
- Support administrative efficiencies to reduce duplication among child- and family-serving state agencies; and
- Submit an annual report of the above to the Wisconsin legislature.

OCMH Activities: In 2017, OCMH staff activities ranged from increasing the awareness of resiliency to addressing the needs of the children and families most impacted by mental health issues. Some highlights included the following:

- OCMH served as the backbone organization for the Children's Mental Health Collective Impact activities which included developing tools to create a resilient Wisconsin; mapping trauma-informed care activities across the state; organizing and facilitating trauma-informed care policy workshops; and aligning agencies to track and augment resource and help lines for families.
- OCMH was awarded a Substance Abuse and Mental Health Services Administration technical assistance grant to increase access to infant mental health consultation and strengthen partnerships across systems serving young children and their families.
- OCMH, in partnership with the Department of Children and Families and the Institute for Child and Family Well-Being, received a federal grant to increase children and families' access to evidence-based mental health treatments along with the integration of parent and youth voice in developing and implementing services.
- OCMH's participation in the Mobilizing Action for Resilient Communities (MARC) resulted in national networking opportunities, stipends for Collective Impact parent and young adult's participation and leadership, creation of resources including a Wisconsin collective impact video, and relationships with several Wisconsin businesses interested in learning about adverse childhood experiences and trauma-informed care.
- As a member of the Fostering Futures steering committee, OCMH staff assisted in national activities including the introduction of a House Resolution (H.R. 443, 2017) and Senate Resolution (S. R. 346, 2017) recognizing the importance and effectiveness of trauma-informed care.

[1] State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act. Wis. Stat. § 51.025(1)

Tracking Wisconsin's Child Well-Being: In the 2014 annual report, the OCMH outlined data related to the prevalence of mental health issues, services available, and system outcomes. In 2016, the OCMH published a set of 48 child well-being indicators focused on children's resilience, risks to well-being, mental health services, and outcomes. In addition to updating the Wisconsin Child Well-Being Indicator dashboard, this year's report includes fact sheets related to Medicaid services including school-based mental health, outpatient mental health treatment, and psychiatric hospitalizations. The fact sheets additionally provide data on child serving systems such as youth justice, education, and child welfare.

Several data points indicate that Wisconsin's children are experiencing increased distress. For example, over the past five years:

- Youth crisis intervention services increased by 25% (2011 to 2015).
- Youth psychiatric emergency detentions doubled (2011 to 2015).
- Youth self-harm rates significantly increased, doubling for females (2011-2014).

In contrast, several trends related to access are more promising:

- 30% more children on Medicaid received mental health services in 2015 compared to 2012.
- Children's outpatient mental health funded by Medicaid increased by 7% from 2013 to 2014, and by 8% from 2014 to 2015.
- Wisconsin tripled the number of children receiving Medicaid funded mental health services in a school setting (2013-2015).
- Waiting lists for long term support services will be eliminated, expanding access to care for approximately 2,600 children with developmental disabilities, physical disabilities, or severe emotional disturbances.

Two additional trends suggest children may be receiving more effective services and supports leading to a decrease in the need for hospitalization and psychotropic medications:

- Children's psychiatric hospitalizations funded by Medicaid decreased by 15% (2015).
- Antipsychotic and stimulant drug prescriptions for children on Medicaid decreased by 37% and 20% respectively over the past 4 years (2012-2016).

Increased Funding: The 2017-2018 biennial budget represented Wisconsin's continued commitment to children's mental health.

- $6,250,000 to improve and expand school mental health services.
- $1.2 million over fiscal year 2018-2019 to develop an eight-bed children's crisis treatment and stabilization facility.
- $500,000 additional funding to expand the Child Psychiatric Consultation Program (CPCP).
- $3,900,000 additional funding to increase access to home visiting.
- $16 million to eliminate the waiting list for long-term supports for approximately 2,600 children with developmental disabilities, physical disabilities, or severe emotional disturbances.

- $200,000 of tribal gaming revenue to fund a feasibility study and business plan for a tribal youth wellness center in northern Wisconsin.[2]

Other good news in 2017 included Wisconsin's Medicaid changes in service authorization, known as "prior authorization," leading to more expedited access to behavioral health services. Additionally, Wisconsin increased Medicaid reimbursement rates for mental health professionals and substance use counselors with the goal of increasing the number of behavioral health providers serving people who are insured through Medicaid.

OCMH Future Activities: In the coming year, the OCMH will continue to address its mission to "innovate, integrate and improve Wisconsin's child and family service systems resulting in thriving children, youth, and families" by implementing the following plans:

Innovate

- Reexamine and restructure the Family Relations Coordinator position resulting in increased integration of parent and young adult leadership in policy and program development across state agencies.
- Create a web-based, interactive state map documenting county and regional collective impact activities.
- Continue disseminating the science of Adverse Childhood Experiences (ACEs) and trauma-informed care (TIC) to Wisconsin businesses.

Integrate

- Expand the Children's Mental Health Collective Impact (CMHCI) initiative to be more representative of Wisconsin's racially, ethnically, and geographically diverse population.
- Increase membership of the Children's Emergency Detention and Crisis Stabilization Services (CEDCS) workgroup to include a wider range of stakeholders including hospitals, schools, and law enforcement representatives.
- Engage the OCMH Research Advisory Council in cross-departmental data analysis and invite participation from the Great Lakes Inter-Tribal Epidemiology Center.

Improve

- Redesign the website with focus areas on intuitive navigation, simple graphics, and interactive tools.
- Promote data-driven policy and program development by broadly distributing the OCMH child well-being indicator dashboard and the fifteen fact sheets contained in this report.
- Continue providing state and national technical assistance in the areas of trauma-informed care, parent and youth leadership, and collective impact.

[2] Please see the appendix for a full description of Wisconsin's budget allocations related to children and families' social and emotional well-being.

OCMH ACTIVITIES

The following pyramid highlights the OCMH's grounding in a public health framework and the OCMH staff's resulting participation in activities spanning the prevention-to-intervention continuum.

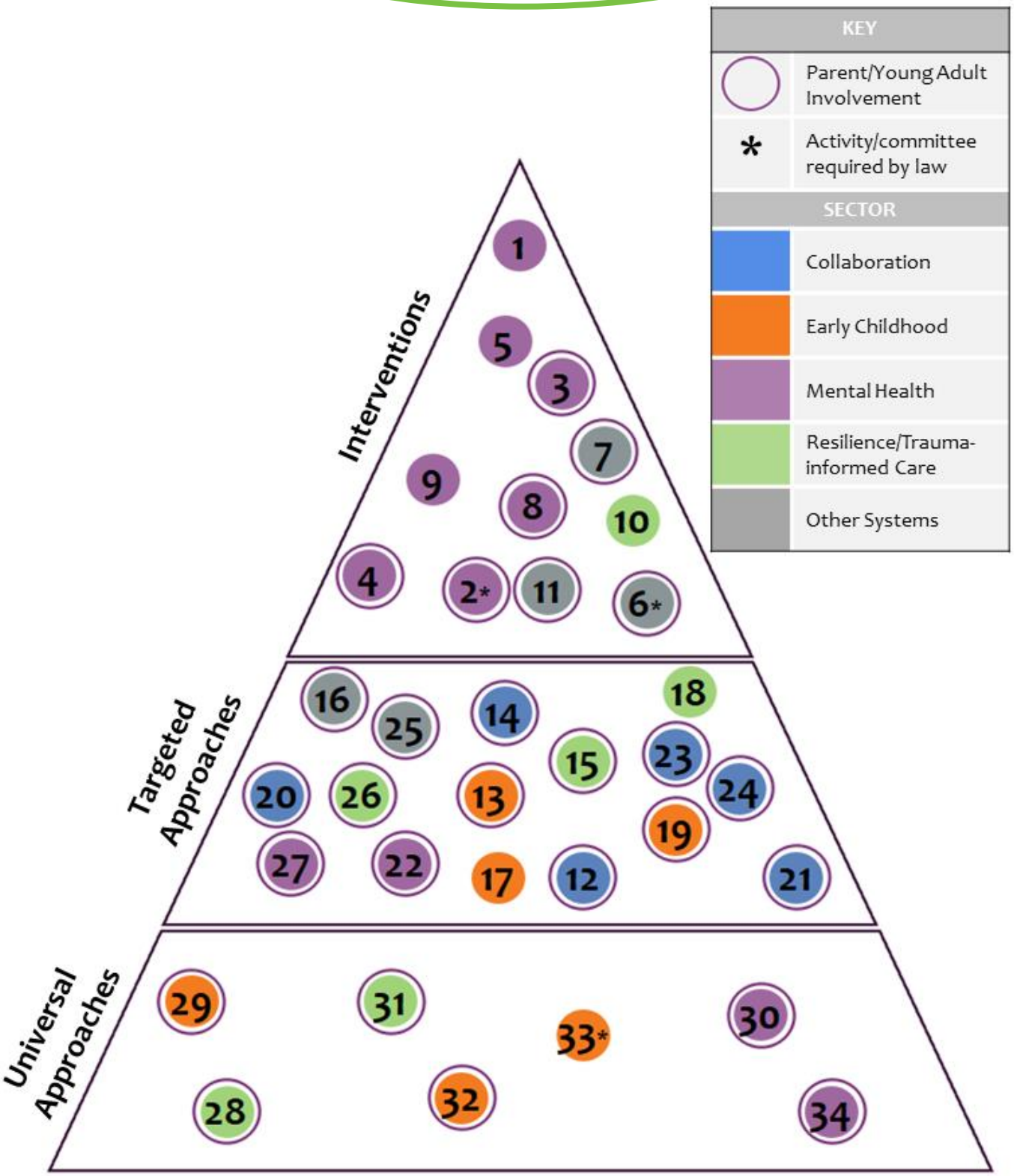
Within this visual depiction of the OCMH activities, the pyramid's base represents prevention efforts with a focus on the general population, often called "universal approaches." The middle of the pyramid signifies activities that may be categorized as early intervention or "targeted approaches" and applies to a subset of the general population. Finally, the tip of the pyramid highlights "interventions" for children and families who have more complex issues requiring mental health treatment.

The following additional information is represented on the following pages:

- Colors represent the activities' focus areas identified as "collaboration, early childhood, mental health, resilience and trauma-informed care, and other."
- A purple ring highlights parent and young adult leadership and involvement.
- The text following the pyramid provides additional information including the state agencies involved. (Please note that many of the activities include wide representation from multiple organizations however this report's main focus is on state agencies' activities.)
- The text includes a brief description of the purpose of the activity, followed by accomplishments and the OCMH's level of involvement.
- Relevant fact sheets complete the activities' descriptions.

State Agency Acronyms:
CANPB – Child Abuse and Neglect Prevention Board
DCF – Department of Children and Families
DHS – Department of Health Services
DOC – Department of Corrections
DPI – Department of Public Instruction
DVA – Department of Veterans Affairs
DWD – Department of Workforce Development
OCMH – Office of Children's Mental Health
WEDC – Wisconsin Economic Development Corporation

OCMH ACTIVITIES AT-A-GLANCE



DESCRIPTION OF OCMH ACTIVITIES

Activities 1-11 (Tip of Pyramid – mental health interventions)

1

Children's Behavioral Health Collaboration (DCF, DHS, OCMH)

Purpose: Address psychotropic prescribing patterns for children on Medicaid with a particular focus on children in foster care.
Accomplishments: Identified medication types and psychotropic prescribing trend data using Medicaid data and contributed to efforts related to decreasing the number of antipsychotics prescribed to children.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- Psychotropic Medication Prescribing (p. 53)

2*

Children Come First Advisory Committee and CCF System of Care Advisory Subcommittee (DCF, DHS, DOC, DPI, DWD, OCMH)

Purpose: Champion statewide collaborative systems of care for children and their families.
Accomplishments: Support for the expansion and improvement of Wisconsin's mental health system of care (e.g., wraparound services and Coordinated Service Teams Initiatives).
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- All

3

Children with Complex Needs (DCF, DHS, OCMH)

Purpose: Identify solutions to address the issue of Wisconsin children being sent out of state for mental health residential care.
Accomplishments: Conducted a root-cause analysis of the problem which included a county and provider; discussed creating a new model for children's mental health residential services; and select members visited Tennessee facility.
OCMH Involvement: Member
Relevant fact sheets:

- Youth Psychiatric Hospitalizations (p. 63)

4

Children's Mental Health Collective Impact Access Workgroup (CANBP, DCF, DHS, DOC, DPI, OCMH)

Purpose: Increase children and families' access to mental health services.
Accomplishments: Promoted the use of the Wisconsin First Step help line and Wisconsin 2-1-1; identified gaps in existing resources; and identified ways to increase parent and youth involvement in developing programs and policies to ensure that programs are driven by family and youth.

OCMH Involvement: Leadership
Relevant fact sheets:

- All

Child Psychiatry Consultation Program (CPCP) Advisory Council (DCF, DHS, DPI, OCMH)
Purpose: Increase primary medical care providers' access to child-focused mental health consultation.
Accomplishments: Increased CPCP enrollment and community mental health referrals.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- Mental Health Providers (p. 45)
- Psychotropic Medication (p. 53)
- Youth Psychiatric Hospitalizations (p. 63)
- Youth Suicide and Self Harm (p. 65)

Children with Disabilities and the Child Welfare System (CANPB, DCF, DHS, DPI, OCMH)
Purpose: Develop and implement plans to improve child abuse and neglect investigations related to children with disabilities.
Accomplishments: Established recommendations which included the following: strengthen assessments; link state agencies' data systems; provide resources to caregivers and professionals; and increase service access for families who are assessed but do not enter the child welfare system.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p. 37)
- Children's Medicaid (p. 41)
- Services for Children with Delays or Disabilities (p. 59)

Child Welfare, DCF Secretary's Advisory Council (CANPB, DCF, DOC, OCMH)
Purpose: Advise the DCF Secretary regarding policy, budget, and program issues that impact the safety, permanence, and well-being of Wisconsin children and families.
Accomplishments: Discussed topics such as mental health services, school-based mental health, disparities within the child welfare system, children with disabilities, and child welfare staff turnover.
OCMH Involvement: Member
Relevant fact sheets:

- All

Emergency Detention and Crisis Stabilization Workgroup (DCF, DHS, OCMH)
Purpose: Reduce youth emergency detentions and improve youth crisis stabilization responses.
Accomplishments: Supported a budget proposal for a crisis stabilization facility and provided county level emergency detention data leading to changed county crisis responses.

OCMH Involvement: Leadership
Relevant fact sheets:

- Child Maltreatment and Out-of-Home-Care (p. 37)
- Crisis Intervention (p. 43)
- Youth Justice (p. 61)
- Youth Psychiatric Hospitalizations (p. 63)
- Youth Suicide and Self Harm (p. 65)

SAMHSA Grant – Trauma and Recovery Collaboration (DCF, OCMH)
Purpose: Increase access to child and family mental health treatments and increase family leadership in program and policy design.
Accomplishments: Awarded grant with activities to begin in 2018.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

Trauma Free Care Workgroup (DCF, DHS, DPI, OCMH)
Purpose: Promote trauma-informed care within congregate care and day treatment settings.
Accomplishments: Identified a curriculum and began planning a summit.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p. 37)
- Crisis Intervention Services (p. 43)
- Youth Justice (p. 61)

Youth Justice, DCF Secretary's Advisory Council (DCF, DOC, OCMH)
Purpose: Advise DCF on supporting a stronger community-based youth justice system with a focus on prevention and diversion, accountability, and services to youth and families.
Accomplishments: Gathered stakeholder input to create a strategic plan that includes the following: training; data collection; technical assistance; developing standards for assessment and the use of detention; gathering input from youth, families and providers; and communicating progress.
OCMH Involvement: Member
Relevant fact sheets:

- All

Activities 12-27 (Middle of Pyramid – targeted approaches)

Children's Mental Health Collective Impact Executive Council (CANPB, DCF, DHS, DOC, DPI, OCMH)
Purpose: Provide guidance to the five collective impact workgroups with a focus on transforming Wisconsin's children's mental health system.

Accomplishments: Increased cross system, public/private network connections; integrated resilience and trauma-informed care into policies and practices; and increased parent and youth involvement and leadership in policy and program development.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

Children's Mental Health Collective Impact Infant Toddler Policy Group (CANPB, DCF, DHS, DPI, OCMH)

Purpose: Increase use of infant mental health consultation and other strategies that promote positive infant/caregiver attachment and healthy early brain development.
Accomplishments: Received a three year technical assistance grant from SAMHSA to develop cross-system infant mental health consultation infrastructure.
OCMH Involvement: Leadership
Relevant fact sheets:

- Children's Medicaid Funded Mental Health Services (p. 41)
- Mental Health Providers (p. 45)
- Resilience (p. 55)
- School Outcomes (p. 57)

Children's Mental Health Collective Impact Trauma-Informed Care (TIC) Workgroup (DCF, DHS, DOC, DPI, OCMH)

Purpose: Promote statewide TIC transformation across child and family serving systems.
Accomplishments: Sponsored five TIC policy workshops and created an interactive map of Wisconsin's TIC initiatives.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

Children's Mental Health Collective Impact Partners (DCF, DHS, OCMH)

Purpose: Promote system-wide parent and youth involvement and leadership in policy and program development.
Accomplishments: See CIP activities on page 21.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

Community of Practice on Autism Spectrum Disorder and other Developmental Disabilities (CANPB, DCF, DHS, DPI, OCMH)

Purpose: Plan, facilitate and evaluate the Community of Practice plan to promote children's healthy social and emotional development.

Accomplishments: Sponsored the learning series, "Mental Health and Autism/Developmental Disabilities" with topics including education and awareness, parent supports and advocacy, professional development, medical homes, and school-age and youth transition issues.
OCMH Involvement: Member
Relevant fact sheets:

- Resilience (p. 55)
- Services for Children with Delays or Disabilities (p. 59)

17

Family Foundations Home Visiting Implementation Team (CANPB, DCF, DHS, DPI, OCMH)
Purpose: Oversee the state plan for home visiting programs.
Accomplishments: Issued a request for proposals; recommended priorities in distributing funding to RFP recipients; and reviewed the annual report provided to the federal government.
OCMH Involvement: Member
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p.37)
- Resilience (p. 55)

18

Fostering Futures (CANPB, DCF, DHS, DOC, DPI, DVA, DWD, OCMH, WEDC)
Purpose: Create state and national trauma-informed care transformation with the leadership of Wisconsin's First Lady, Tonette Walker.
Accomplishments: Completed phase two and initiated phase three TIC transformation with a focus on county service systems and state agencies; initiated broader state and national awareness of the importance of TIC; and supported the proposed House and Senate TIC resolutions.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p. 37)
- Collective Impact Resilience (p. 27)
- Collective Impact Trauma-Informed Care (p. 25)
- Resilience (p. 55)

19

Head Start Collaboration Advisory Committee (DCF, DHS, DPI, OCMH)
Purpose: Enhance the coordination and collaboration among Head Start and Early Head Start agencies and other stakeholders who provide services to low-income children and their families.
Accomplishments: Initiated a spreadsheet of data resources for needs' assessments; supported collaboration, blended funding and data collection between participating Head Start programs and child care centers; and promoted resources for trauma-informed transformation in early care and education.
OCMH Involvement: Member
Relevant fact sheets:

- Collective Impact Trauma-Informed Care (p. 25)
- Resilience (p. 55)

Leading Together (CANPB, DCF, DHS, DPI, OCMH)

Purpose: Developed a list of resources and activities that promote the development of families' leadership skills.

Accomplishments: Developed a curriculum for integrating family participation in medical homes and created a family leadership resource page located on the Family Voices' website.

OCMH Involvement: Member and workgroup

Relevant fact sheets:

- Children's Medicaid (p. 41)
- Outpatient Mental Health (p. 51)
- Mental Health Providers (p. 45)
- Psychotropic Medication Prescribing (p. 53)
- Services for Children with Delays or Disabilities (p. 59)

Medical Home Implementation Team (CANPB, DHS, DCF, DPI, OCMH)

Purpose: Increase access to medical homes for Wisconsin's children and youth with special health care needs.

Accomplishments: Created a care coordination curriculum; produced promotional materials; added new resources to Wisconsin First Step, the children's behavioral health online resource directory; and increased medical home enrollment for children with special health care needs.

OCMH Involvement: Member and workgroup

Relevant fact sheets:

- Children's Medicaid (p. 41)
- Outpatient Mental Health (p. 51)
- Mental Health Providers (p. 55)
- Psychotropic Medication Prescribing (p. 53)
- Services for Children with Delays or Disabilities (p. 59)

Parent Peer Specialist Workgroup (DHS, DPI, OCMH)

Purpose: Create a Wisconsin certification process for Parent Peer Specialists. See timeline.

Accomplishments: Developed scope of practice, core competencies, code of ethics, and continuing education requirements.

OCMH Involvement: Member and workgroup

Relevant fact sheets:

- Mental Health Providers (p. 45)
- Outpatient Mental Health (p. 51)

Research Advisory Council (DCF, DHS, DOC, DPI, DWD, OCMH)

Purpose: Establish a network of data analysts focused on improving child well-being who represent state agencies, tribal communities, and other stakeholders.

Accomplishments: Created a Tableau user group; discussed disaggregating data by race; and reviewed the OCMH fact sheets.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

State Agencies' Collaborative on Child Well-Being (CANPB, DCF, DHS, DOC, DPI, OCMH)
Purpose: Promote policy and program awareness and alignment across state agencies.
Accomplishments: Created two document housed on the OCMH website – one highlighting collaborative projects and initiatives and the other, a list of state-led meetings involving children's social and emotional development.
OCMH Involvement: Leadership
Relevant fact sheets:

- All

State Management Team for Safe Schools, Healthy Students, and Project AWARE (DCF, DHS, DPI, OCMH)
Purpose: Support school districts and communities focused on enhancing safety, support, and behavioral health awareness.
Accomplishments: Trained adults in Youth Mental Health First Aid; provided suicide prevention trainings; updated the suicide prevention curriculum.
OCMH Involvement: Member
Relevant fact sheets:

- Children's Medicaid (p. 41)
- Crisis Intervention (p. 43)
- Mental Health Providers (p.45)
- Mental Health Services in Schools (p. 47)
- Outpatient Mental Health (p. 51)
- Resilience (p. 55)
- School Outcomes (p. 57)
- Youth Psychiatric Hospitalizations (p. 63)
- Youth Suicide and Self Harm (p. 65)

Trauma Sensitive Schools (DCF, DPI, OCMH)
Purpose: Provide TIC training focused on universal approaches; targeted strategies for student who need additional supports; and intensive interventions for students who require ongoing support.
Accomplishments: Created the Trauma Sensitive Schools learning modules which are used throughout Wisconsin and nationally.
OCMH Involvement: Member
Relevant fact sheets:

- All

27

Wisconsin Council on Mental Health Children and Youth Subcommittee (DCF, DHS, DPI, OCMH)

Purpose: Advise the governor, the legislature and DHS on the allocation of Mental Health Block Grant (MHBG) funds and evaluate the mental health system's progress in increasing service access and improving child and family service outcomes.

Accomplishments: Provided feedback on the MHBG needs' assessment and plan; studied infant mental health consultation and mental health workforce retention; and recruited a parent to join the subcommittee.

OCMH Involvement: Member

Relevant fact sheets:

- All

Activities 28-34 (Bottom of pyramid – universal or population-based approaches)

28

Children's Mental Health Collective Impact Resiliency Workgroup (CANPB, DCF, DHS, DOC, DPI, OCMH)

Purpose: Increase child, family, agency, and system resiliency across Wisconsin.

Accomplishments: Created and piloted resiliency presentations; developed a list of resilience building resources; piloted "Building a Resilience Culture"; and compiled a list of strength-based questions to integrate into child and family assessments.

OCMH Involvement: Leadership

Relevant fact sheets:

- Collective Impact Resiliency (p. 27)
- Mental Health Services in Schools (p. 47)
- Resilience (p. 55)

29

Maternal Child Health Advisory Committee (DCF, DHS, DPI, OCMH)

Purpose: Advise Wisconsin's maternal and child health and children and youth with special health care needs programs on improving the well-being of infants, children, adolescents, and children and youth with special health care needs.

Accomplishments: Included TIC and resiliency training requirements in an RFP for a state-wide resource help line and developed a five year action plan.

OCMH Involvement: Member

Relevant fact sheets:

- Children's Demographics and Well-Being (p. 39)
- Services for Children with Delays and Disabilities (p. 59)
- Youth Suicide and Self-Harm (p. 65)

30

Media Activities (USA Today-Wisconsin)

Purpose: Raise awareness and promote citizen action on a wide range of topics related to children's mental health.

Accomplishments: USA Today-Wisconsin hosted suicide prevention trainings across the state; facilitated community discussions following the airing of "13 Reasons Why"; reported on TIC activities; and monitored children's mental health through continued "Kids in Crisis" reporting and the Legislative Action Tracker.
OCMH Involvement: Resource
Relevant fact sheets:

- Crisis Intervention Services (p. 43)
- Mental Health Providers (p. 45)
- Mental Health Services in Schools (p. 47)
- Outpatient Mental Health (p. 51)
- Youth Psychiatric Hospitalizations (p. 63)
- Youth Suicide and Self-Harm (p. 65)

Mobilizing Action for Resilient Communities (MARC) (OCMH, WEDC)
Purpose: Create sustained positive impact on all child-serving systems by including the voice of lived experience in system-wide quality improvement and disseminate the science of ACEs and resilience to Wisconsin businesses.
Accomplishments: Provided financial reimbursement for parent and young adults' expertise, time, and travel costs; provided pre and post meeting information and resources to enhance parent/youth leadership and participation; and presented a resilience-focused curriculum and mindfulness app to businesses.
OCMH Involvement: Leadership
Relevant fact sheets:

- Collective Impact Resilience (p. 27)
- Collective Impact Trauma-Informed Care (p. 25)
- Resilience (p. 55)

Strengthening Families in Early Care and Education (CANPB, DCF, DHS, DPI, OCMH)
Purpose: Enhance connections with early care and education systems as a means of preventing child abuse and neglect and strengthening family resiliency.
Accomplishments: Developed a survey to gather information on how Strengthening Families is being implemented across Wisconsin's child serving systems and held two train-the-trainer sessions for *Bring the Protective Factors to Life in Your Work*.
OCMH Involvement: Member
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p. 37)
- Children's Demographics and Well-Being (p. 39)
- Resilience (p.55)

Wisconsin Governor's State Advisory Council on Early Childhood Education and Care (CANPB, DCF, DHS, DPI, DOC, OCMH)

Purpose: Advise the DCF Secretary and the DPI Superintendent on strategies to promote healthy early childhood development.
Accomplishments: Created three proposals for the Governor's consideration and received funding in the 2017-2018 state budget for home visiting.
OCMH Involvement: Member
Relevant fact sheets:

- Child Maltreatment and Out-of-Home Care (p. 37)
- Resilience (p. 55)
- School Outcomes (p. 57)

34

Wisconsin Knows Children's Mental Health Matters Coalition (DCF, DHS, DPI, OCMH)
Purpose: Destigmatize mental health issues and promote children's mental health awareness.
Accomplishments: Held a ceremony and recognized winners of the "My Feelings Matter" poster contest.
OCMH Involvement: Member and workgroup
Relevant fact sheets:

- All

CHILDREN'S MENTAL HEALTH COLLECTIVE IMPACT

Wisconsin's Children's Mental Health Collective Impact (CMCI) Initiative: The OCMH serves as the "backbone" organization which means that OCMH staff does the following to support collective impact activities:

- Support parent and youth participation,
- Provide topic-related data and research,
- Facilitate agenda setting,
- Co-create power points and other presentation material,
- Provide handouts,
- Arrange meeting space,
- Takes notes,
- Provide refreshments,
- Oversee technology for virtual participation, and
- Maintain continuous communication.

The CMHCI's membership includes a wide range of stakeholders who make up the executive council and five workgroups. Combined, these groups have focused on the following actions:

- Aligning child and family serving systems to increase coordination resulting in better outcomes and the reduction of families' confusion and stress related to siloed services,
- Bringing data and analysis to state agencies and the general public,
- Identifying easier, single-access entry, into mental health services,
- Integrating trauma-informed care into a wide range of service sectors,
- Presenting information across Wisconsin on the topic of resilience and what makes children and families strong during times of stress and adversity.

The following pages represent more information about collective impact activities.

This page is intentionally left blank.

Children's Mental Health Collective Impact Executive Council

Collective Impact: Collective is a structured approach to systems change. The process brings together a wide variety of stakeholders who use data to identify root causes of a problem. Once the problem's complexity is understood, the group implements solutions and monitors outcomes by using shared measures.

The Wisconsin Children's Mental Health Collective Impact is populated by a wide range of stakeholders who make up the executive council and workgroups. The executive council sets the common agenda and receives updates on workgroup progress. The workgroups identify and implement strategies to address identified issues while data-driven decisions guide the process.

The OCMH serves as the "backbone" which includes activities such as arranging meeting space, taking notes, overseeing technology, facilitating the creation of agendas, supporting parent and youth membership, and providing data and cross system information. OCMH also creates and maintains tools such as dashboards, visual mapping, and websites.

Collective Impact Framework

Common Agenda	Participants come to a common understanding of the problem, a joint approach to solving it, and a shared vision of change.
Shared Measurement	After collecting data, participants agree on a common set of indicators to monitor outcomes and track progress.
Mutually Reinforcing Activities	Activities are coordinated through a mutually reinforcing plan of action.
Continuous Communication	Trust is built through consistent and open communication resulting in mutual objectives and shared motivation.
Backbone Support	Underlying all activities is a dedicated staff with skills in planning, facilitation, communication, data collection and analyses.

Collective Impact Partners (CIPs): Improving the service systems requires leadership and input from people who have experienced services first hand. For this reason, parents and youth co-chair or participate in all collective impact activities. Their voice and experiences help to inform the organizations of positive developments, reach and scope of services, service missteps, and unhelpful or cumbersome policies and practices.

Executive Council (Page 2)

The Wisconsin Children's Mental Health Collective Impact Executive Council provides guidance and strategic direction to the collective impact workgroups. After accumulating data and information about the problems, workgroups propose solutions, implementation strategies, and monitor and activities.

In addition to the four collective impact workgroups already in place (access, trauma-informed care, resiliency and Collective Impact Partners), the Executive Council agreed to add a fifth group focused on infant and early childhood mental health consultation.

Each workgroup meets monthly to work on strategies and then presents activities and challenges to the executive council for large group analysis.

In 2017, workgroup challenges included the following: increasing network connections; improving communication; allotting enough time and having enough data for root cause analysis; creating lasting systems' change; integrating resilience and trauma-informed care into agencies' policies and practices; and increasing parent and youth voice in policy and program development.

Relationships established in collective impact have resulted in increased collaboration on initiatives as well as increased inclusion of parent leadership across state agencies.

Mission
Every child is safe, nurtured and supported to promote optimal health and well-being.

Access to Supports and Services
Wisconsin's infants, children, youth and their families have timely access to high quality, trauma-informed, culturally appropriate mental health services that promote children's social and emotional development.

Trauma-informed Care Implementation
Systems are family-friendly, trauma-informed, easy to navigate, equitable, and inclusive of people with diverse cultures, ethnicity, race, gender identity, sexual orientation and socio-economical status.

Availability of Resilience Tools
All Wisconsin's infants, children, youth and their families have accurate and timely information and supports needed for socio-emotional development, optimal mental health and resiliency, including relationships and social networks that provide friendship, love and hope.

Shared Measures
The Executive Council asked each workgroup to choose three of the 48 indicators from the Office of Children's Mental Health Child Well-Being Indicator dashboard to measure workgroup progress. Workgroups will report progress after the release of each year's new Indicator dashboard.

Key Takeaways:
- Promote awareness of existing resources for families and providers
- Promote a no wrong door or single point of entry for children's mental health services
- Increase parent and youth voice in the system of care
- Make data driven decisions

Wisconsin Children's Mental Health Collective Impact Partners (CIPs)

Who are the CIPs?

Collective impact parent/caregiver and young adult partners, also known as CIPs, bring decades of "lived experience" having been enrolled or involved in child- and family-serving systems such as mental health, special education, juvenile justice, and/or child welfare, to their participation and leadership in the Children's Mental Health Collective Impact Executive Council meetings and workgroups.

The CIPs are big-picture, systems thinkers. With their insights and guidance, state agencies and other collaborating partners are better able to recognize gaps in services, deficient programs, and unhelpful or cumbersome policies and practices.

Seated from left to right: Joe Ziementz, Tina Buhrow, Kenya Bright (DHS staff), Tabitha DeGroot. Standing: Corbi Stephens, Micheal Bostrom, Rob Kaminski, Kayla Sippl (DHS staff), Alison Wolf, Kimberlee Coronado, Bob Fredericks, Joann Stephens (OCMH staff).

Parent and Youth Voice in System Change

CIPs are a valuable resource and are sought after by organizations and governmental agencies to provide expert consultation in many areas, the following serve as an example of their work:

- Staffing workgroups
- Developing and reviewing policies and resources
- Providing presentations
- Sitting on hiring panels
- Supporting other parent and youth leaders

CIPs Build Skills in Parent and Youth Advocates

In coordination with the Wisconsin Office of Children's Mental Health (OCMH) Family Relations Coordinator, CIPs develop and host trainings to develop skills not only for CIPs but for any interested Wisconsin parents and young adults.

Trauma-informed Care 101

In November 2016, fifty-three parents and young adults learned about the impact and prevalence of trauma, steps to becoming to become trauma-informed, and how to engage child- and family-serving systems in the implementation of trauma-informed care. Two thirds of the participants were already engaged in systems change activities within Wisconsin's Department of Children and Families, Department of Health Services, Department of Public Instructure, Department of Corrections, along with numerous county and local programs.

Resilience Summit

In September, 2017, 24 parents, youth, and providers gathered together to complement their understanding of how early adversity, toxic stress, and trauma impact the mind and body. The CIPs this Resilience Summit to learn about and educate others on topics related to building resilience within the self, family, and community. Participants came out of the summit with a call to action, committing to:

- "Look for ways my community can encourage resiliency"
- "Incorporate protective factors in my own work and trainings"
- "Sit down and talk to my daughter about what I learned"

Parents and youth learn tools to tip the scale towards resilience.

Town Hall Meetings

- CIPs represented parent and youth voice at Kids in Crisis town hall meetings that happened around the state, sponsored by the USA Today Network - Wisconsin. Town hall meetings provided Question Persuade Refer (QPR) suicide prevention trainings.

Wisconsin Children's Mental Health Collective Impact Partners (CIPs) (page 2)

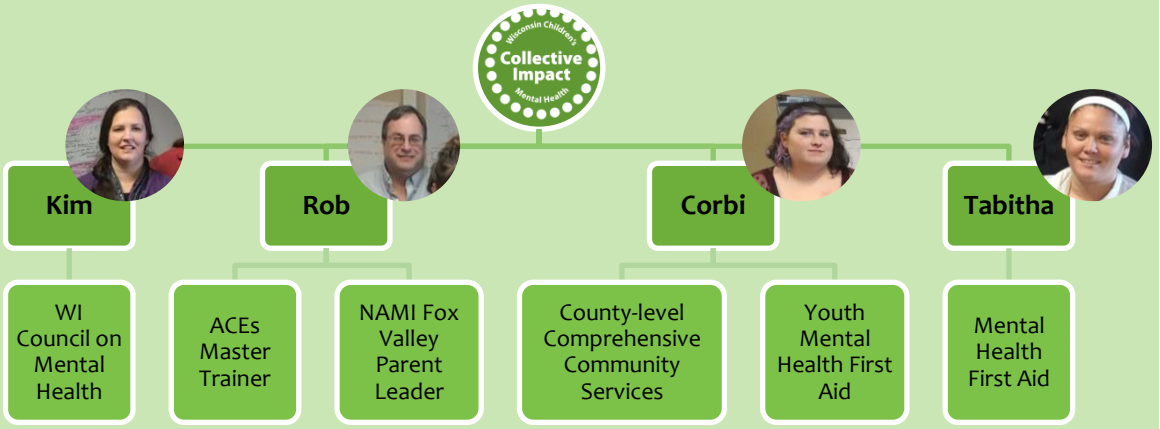
CIPs Engage Communities in Transformation

As parents and young people engage in Collective Impact, they not only provide consultation to others, but also continue to develop their knowledge, confidence, and leadership with regard to systems' operations, programs, and resources. Many CIPs additionally enroll in or present at local trainings and conferences in their communities.

Network of Support

CIPs not only receive support from the OCMH, they also support one another.

As members of Collective Impact, CIPs create a network of connections with continuous feedback loop ensuring ongoing quality improvement.



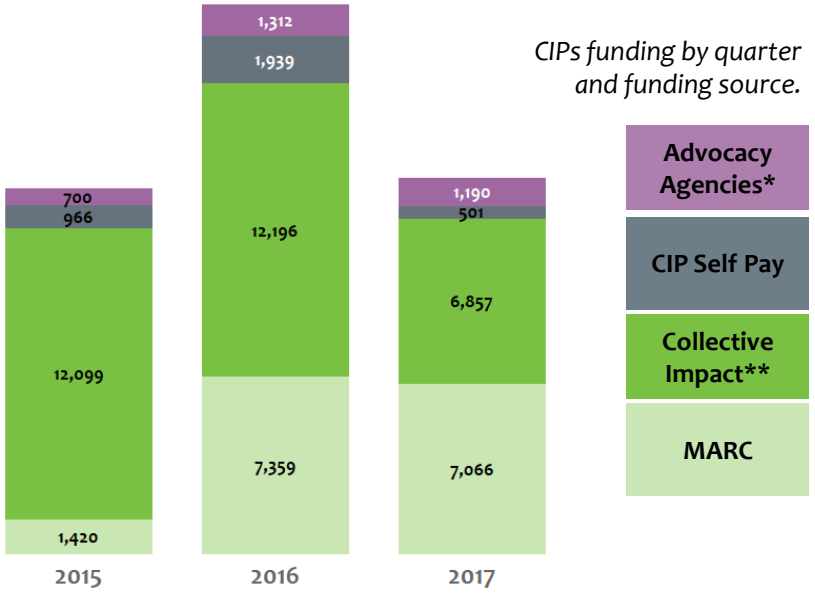
Funding CIPs Work

The CIPs are paid for their consultation time in the form of a stipend and are also reimbursed for travel expenses such as mileage and food.

Funding CIPs leadership and participation comes from multiple sources. State agencies (Department of Children and Families & Department of Health Services) and a hospital partner (Children's Hospital of Wisconsin) have generously contributed to the pool.

In 2017, 32% of the funding came from the Mobilizing Action for Resilient Communities (MARC) grant which ends in December of 2017.

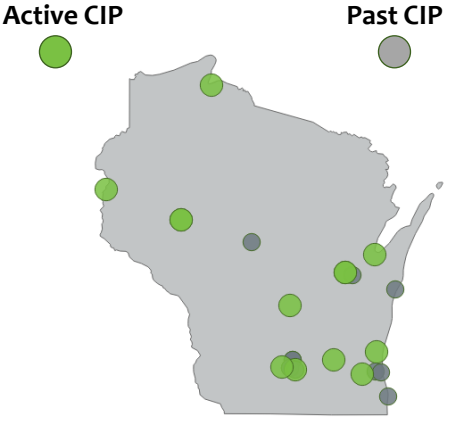
Many CIPs also volunteer their time and expenses, funding about 10% of the total cost (see graph below). Funding for conferences , trainings and presentations, as well as respite and child care are unfunded.



*"Advocacy Agencies" includes Access to Independence, NAMI Wisconsin, and Wisconsin Family Ties.
**"Collective Impact" includes funding from partner agencies such as the Department of Health Services, Department of Children and Families, and Children's Hospital of Wisconsin.

Representing Wisconsin Parents and Youth

The Wisconsin Children's Mental Health Collective Impact draws expertise from across the state.



"When I arrived at the first [Collective Impact] meeting, I was overwhelmed by the depth (and number) of key contributors were there to participate. Most impressive was the inclusion of parents and teens with lived experience. In all the policy and work groups I've participated, there have never been "consumers" involved in the process. [Now,] my own mission is to make participation from families and children a natural and fundamental part of our work, rather than a novelty."

-Kia LaBracke, Wisconsin Chapter of the Academy of Pediatrics

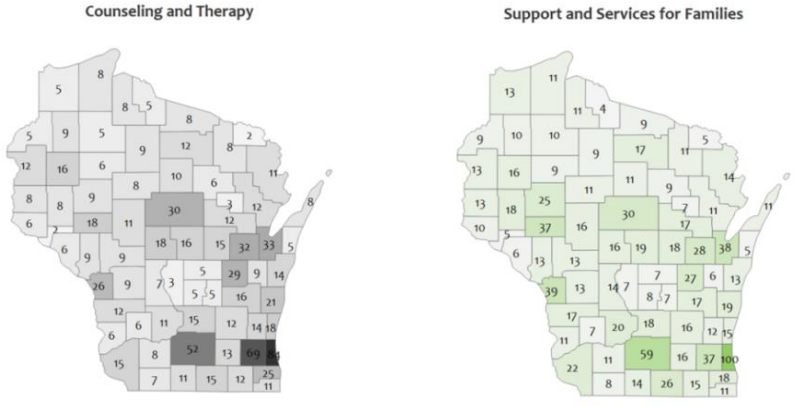
Children's Mental Health Collective Impact Access Workgroup

Nationally, one in five children has a diagnosable mental health issue with only 10 to 40% accessing treatment. The Access Workgroup aims to create a system that will identify and provide appropriate and quality services to children, as early as possible, before challenges become more complex.

Raising Awareness of Resources

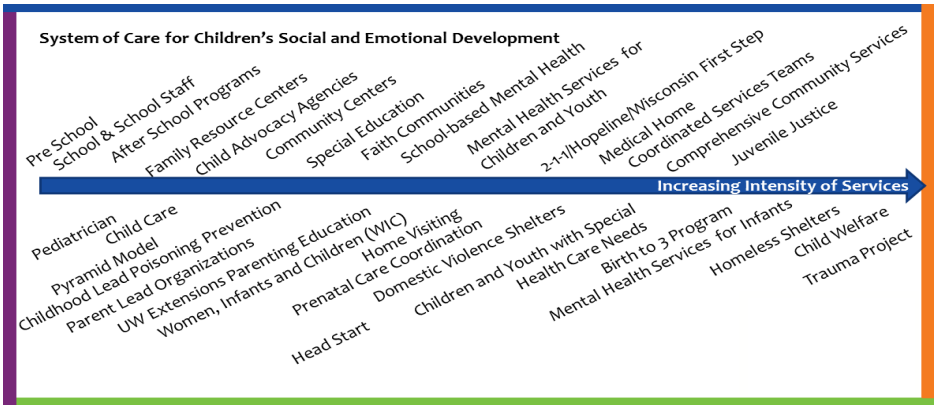
One of the biggest barriers preventing families from accessing help is not knowing about available services and supports. A Wisconsin Children and Youth with Special Health Care Needs Medical Home Systems Integration Project[1] group worked to address this issue by identifying and integrating children's mental health services into the Wisconsin First Step (WFS) data base. The access workgroup distributed promotional material throughout child-serving systems. The workgroup is committed to identifying additional resources and promoting the WFS and Wisconsin 2-1-1 (another key resource line in Wisconsin) as ways for families and professionals to connect to needed services.

Example of information provided by WFS
Number of providers of each type of service, by county (2017)



A Statewide System of Care

The workgroup reviewed available services along the continuum of mental health services and supports, often called a "system of care." Future activities will include identifying and promoting successful regional resources to communities across the state.



Goal Statement

Wisconsin's children, youth, and families have timely access to high quality, trauma-informed, and culturally appropriate mental health services that promote children's social and emotional development.

Key Activities

- Promote awareness of existing resources for families and providers.
- Assess service and support gaps.
- Identify ways to increase parent and youth involvement in policy and program development.
- Identify and implement best practices in increasing access to services.

Access Workgroup Indicators

The Access Workgroup will track success by using the following measurements:

- Availability of child, family, and school social workers
- Early childhood screening
- Insurance coverage for children

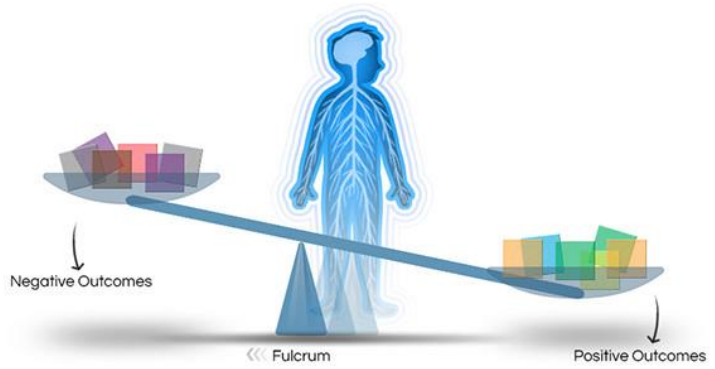
Learn more by visiting https://children.wi.gov/Pages/Integrate/AccessWorkgroup.aspx

Tipping the Scale

Wisconsin's future success relies on the health and well-being of our children. To ensure new generations of productive, conscientious citizens, we must counter any negative experiences that cause toxic stress with protective factors.

The Office of Children's Mental Health is using the metaphor of a scale[2] to think of the course of a child's development. A scale has two ways to tip the balance, the counterbalance and the fulcrum or balancing point. In the metaphor, the positive experiences or protective factors, are loaded on to one side of the scale while the challenges or risk factors are on the other side. If the scale is loaded with positive experiences (not all experiences hold the same weight) the scale tips in a positive direction. A person with a scale tipped toward the negative side has increased risk of negative heath outcomes.

Tipping the scale towards positive outcomes by ensuring that families and youth have access to appropriate and quality supports and services



The Role of Genes

The second way to tip the scale is to move the fulcrum. Besides experiences, genes also play a role. In this metaphor the fulcrum represents the genetic inheritance of a person. Some people are born more susceptible to toxic stress and others are less effected. Research into epigenetics has found that the fulcrum is not permanently set. There are pivotal times in a child's development when experiences can modify how genes are expressed. These times, such as the first five years of a child's life, the passage to adolescence and the transition to adulthood, are critical periods where intervention has a greater impact on long-term well-being. Leveraging resources to enhance supports at these critical times is a wise investment in our children's future.

The Community's Role

A child's community plays an important role. The network of community relationships, environments and opportunities all lay the groundwork for the next generation. Parents play key roles in a child's life, and other adults can as well. An attentive child care provider, teacher, coach or neighbor can bolster a child's resilience against toxic stress. We can change the trajectory of the next generation by increasing broad-based understanding in communities around the importance of a child's social and emotional development, and bolstering resources for children and families.

Access in Action

Below are a few examples of Wisconsin activities underway to improve access to services and supports:

- School districts are better at identifying children's needs and connecting them to providers. Recent Wisconsin legislation will make it possible to expand school-based mental health services.
- Mental health providers are supported with learning opportunities including training on Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction therapy and Child Parent Psychotherapy.
- Students are developing stigma reduction campaigns and peer support groups in their schools.
- Adults across the state are being trained in Youth Mental Health Frist Aid to help adolescents who are experiencing a mental health or addictions challenge.
- The Child Psychiatry Consultation Program is available in areas of the state to assist primary care clinicians in delivering better informed mental health care.

1. Funded by the federal Maternal and Child Health Bureau of the Health Resources and Service Administration.
2. Kendall-Taylor, Nathaniel. (2012). The Resilience Scale: Using Metaphor to Communicate a Developmental Perspective on Resilience. Washington, DC: FrameWorks Institute.

Children's Mental Health Collective Impact Trauma-Informed Care Action Team

Children who are impacted by toxic stress or trauma often don't have the language to describe their complex emotions. Instead, they may have difficulty learning , trusting adults, developing healthy relationships, or they may have unexplained physical symptoms like head and stomachaches. Being curious about what underlies these issues may lead to helpful interventions that could prevent long term negative impacts.

TIC is a framework that highlights the prevalence and impact of adverse childhood experiences (ACEs), toxic stress, and trauma. This information becomes the foundation in understanding how to reshape interpersonal interactions, organizational operations, and community activities.

Key Activities

- Increase awareness of trauma-informed care activities in tribes and counties through mapping initiative.
- Promote trauma-informed care transformation through policy change workshops.

Trauma-Informed Care Policy and Practice Workshops

The Trauma-Informed Care Action Team (TICAT) facilitates a TIC learning community focused on organizational trauma-informed care transformation. In partnership with Wisconsin's state agencies' Area Administration, the TICAT presented four workshops to provide over 300 attendees with practical TIC tips. Topics included the following:

- Consumer Involvement and TIC transformation
- Human Resources from a TIC perspective
- Organizational TIC transformation

Mapping Trauma-Informed Care Activities

The Trauma-informed Care Action Team has been mapping the initiatives and agencies across the state who are undergoing the trauma-informed care transformation. Agencies across Wisconsin completed a survey providing information about their TIC transformation. The map provides contact information so communities or sectors can connect their efforts and learn from each other. The TIC maps and additional data can be found at https://children.wi.gov/Pages/Integrate/TICMap.aspx

Trauma-Informed Care Action Team Indicators

The TIC Action Team will track their success using the following measurements:

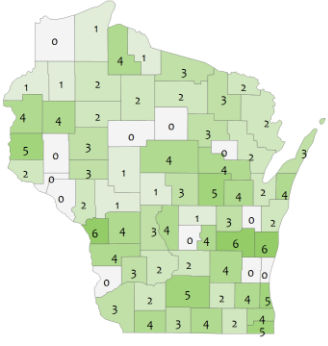
- Percent of children with two or more ACEs
- Spending on mental health and substance use treatment
- Juvenile arrest rate

Number of TIC initiatives within each county or tribe

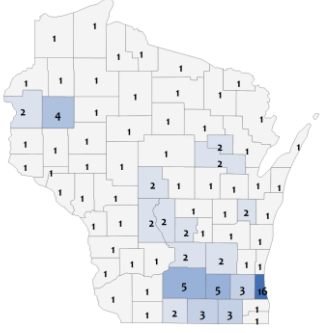
Initiatives include the following:

- Child Welfare in the Courts
- Fostering Futures
- Trauma-Sensitive Schools
- Wisconsin Trauma Project:
  - TF-CBT
  - Trauma-Informed Parenting

Bad River Tribe	0
Forest Potawatomi Tribe	2
Ho Chunk Nation (Tribe)	1
Lac Courte Oreilles	3
Lac du Flambeau Tribe	2
Menominee Nation (Tribe)	4
Red Cliff Tribe	1
Sokaogon Chippewa Tribe	0
St. Croix Tribe	2
Stockbridge-Munsee Tribe	1



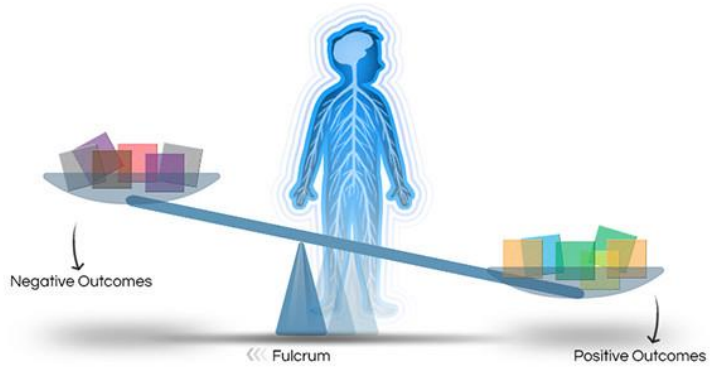
Number of Wisconsin agencies engaged in TIC transformation



Tipping the Scale

Wisconsin's future success relies on the health and well-being of our children. To ensure new generations of productive, conscientious citizens, we must counter any negative experiences that cause toxic stress with protective factors.
The Office of Children's Mental Health is using the metaphor of a scale[2] to think of the course of a child's development. A scale has two ways to tip the balance, the counterbalance and the fulcrum or balancing point. In the metaphor, the positive experiences or protective factors, are loaded on to one side of the scale while the challenges or risk factors are on the other side. If the scale is loaded with positive experiences (not all experiences hold the same weight) the scale tips in a positive direction. A person with a scale tipped toward the negative side has increased risk of negative heath outcomes.

Tipping the scale towards positive outcomes by ensuring that families and youth have access to appropriate and quality supports and services



The Role of Genes

The second way to tip the scale is to move the fulcrum. Besides experiences, genes also play a role. In this metaphor the fulcrum represents the genetic inheritance of a person. Some people are born more susceptible to toxic stress and others are less effected. Research into epigenetics has found that the fulcrum is not permanently set. There are pivotal times in a child's development when experiences can modify how genes are expressed. These times, such as the first five years of a child's life, the passage to adolescence and the transition to adulthood, are critical periods where intervention has a greater impact on long-term well-being. Leveraging resources to enhance supports at these critical times is a wise investment in our children's future.

The Community's Role

A child's community plays an important role. The network of community relationships, environments and opportunities all lay the groundwork for the next generation. Parents play key roles in a child's life, and other adults can as well. An attentive child care provider, teacher, coach or neighbor can bolster a child's resilience against toxic stress. We can change the trajectory of the next generation by increasing broad-based understanding in communities around the importance of a child's social and emotional development, and bolstering resources for children and families.

Trauma-Informed Care in Action

- Communities: Along with media outreach, TIC champions have sponsored community movie nights featuring *Resilience* and *Paper Tigers.* These moving have served as a platform to discuss trauma and resilience in the communities.
- Schools: A process called "Handle with Care" is in place to notify educators that a child has experienced a recent trauma. Educators are not provided details about the event but are given noticed that a child and family may benefit from greater sensitivity and care.
- Organizations: Many social service agencies have integrated questions about a person's trauma history and subsequent symptoms as part of the assessment process.
- Government: County, tribal and state agencies are implementing TIC changes into their human resource practices, work policies, and trainings.

1. Kendall-Taylor, Nathaniel. (2012). The Resilience Scale: Using Metaphor to Communicate a Developmental Perspective on Resilience. Washington, DC: FrameWorks Institute.

Children's Mental Health Collective Impact Resiliency Workgroup

Children who develop resilience are better able to manage stress and feelings of anxiety. More generally, developing resilience creates a social and emotional foundation for learning, developing relationships, development, and general well-being.

In 2017, workgroup members presented across the state on the importance of developing resilience within a child's ecological system which includes the child, adults surrounding the child, communities holding the family, and organizations within the community. A take-away message is the transformative power of a resilience in creating stronger individuals, families, communities, and organizations.

Key Activities

- Promote resilience by creating community awareness of skills, experiences, and resources that create resilience in children and families.
- Develop a web-based toolkit with resources including research, video links, and presentation materials.
- Promote organizational resilience to support the workforce (see below).

Workgroup Values

- Experience a sense of belonging & connection through relationships & supports.
- Foster our inner strengths & hopes.
- Nurture positive qualities in self & others.
- Mentor for success & self-determination.
- Find strength & value in my journey.

Children

Children learn skills related to resilience through relationships with supportive adults and by engaging in opportunities for learning and creativity.

Family

Adults who regularly interact with children are the most powerful lever for creating a child's positive attitudes, beliefs and behaviors.

Community

Community members, who have interest and involvement in a child's life, who listen without judgement can build resilience in children and families.

Organizations

Organizations can increase employee productivity and satisfaction by valuing and empowering staff, and promoting a positive, strength-based workplace.

Culture

Honoring cultural differences in the definition and display of resilience is critical. Resilience grows when children access their own and other cultures.

Resiliency Workgroup Indicators

The Resiliency Workgroup will track success by using the following measurements:

- Flourishing behaviors
- Percent of children with an adult mentor
- Percent of adults with positive mental health

Creating Organizational Resilience

- Educate leadership on the importance of resilience and have them lead by example.
- Create a safe and supportive work environment.
- Encourage employees to support their well-being.
- Develop policies and practices that empower employees to build resilience Build organizational resilience through trauma- informed care transformation.

Resiliency Workgroup (Page 2)

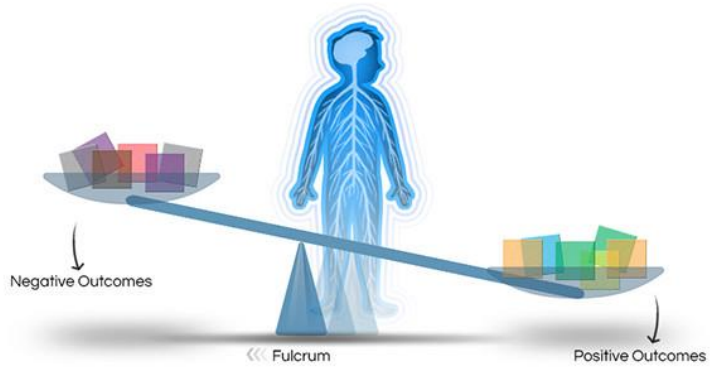
Tipping the Scale

Wisconsin's future success relies on the health and well-being of our children. To ensure new generations of productive, conscientious citizens, we must counter any negative experiences that cause toxic stress with protective factors.
The Office of Children's Mental Health is using the metaphor of a scale[2] to think of the course of a child's development. A scale has two ways to tip the balance, the counterbalance and the fulcrum or balancing point. In the metaphor, the positive experiences or protective factors, are loaded on to one side of the scale while the challenges or risk factors are on the other side. If the scale is loaded with positive experiences (not all experiences hold the same weight) the scale tips in a positive direction. A person with a scale tipped toward the negative side has increased risk of negative heath outcomes.

The Role of Genes

The second way to tip the scale is to move the fulcrum. Besides experiences, genes also play a role. In this metaphor the fulcrum represents the genetic inheritance of a person. Some people are born more susceptible to toxic stress and others are less effected. Research into epigenetics has found that the fulcrum is not permanentl set. There are pivotal times in a child's development whe experiences can modify how genes are expressed. These times, such as the first five years of a child's life, the passage to adolescence and the transition to adulthood, are critical periods where intervention has a greater impa on long-term well-being. Leveraging resources to enhanc supports at these critical times is a wise investment in ou children's future.

Tipping the scale towards positive outcomes by ensuring that families and youth have access to appropriate and quality supports and services



The Community's Role

A child's community plays an important role. The network of community relationships, environments and opportunities all lay the groundwork for the next generation. Parents play key roles in a child's life, and other adults can as well. An attentive child care provider, teacher, coach or neighbor can bolster a child's resilience against toxic stress. We can change the trajectory of the next generation by increasing broad-based understanding in communities around the importance of a child's social and emotional development, and bolstering resources for children and families.

Resilience in Action

- Communities: Parents run peer groups based on the Protective Factors. The protective factors framework provides guidance on attributes of individuals, families and communities that increase the health and well-being of children and families.
- Early Care and Education: Child care providers often build resilience in children through fulfilling more than their basic needs. Through nurturing relationship-based care they give children learning opportunities in safe and responsive environments that support children's social emotional growth and needs.
- Schools: Teachers communally reviewed a list of all students in their school, identified which students didn't have a strong connection with any teacher, and made the effort to get to know those students so every child had a connection to an adult at the school.
- Organizations: Individuals and leaders commit to self-care, including taking lunch breaks, holding walking meetings, and checking in with their co-workers.
- Government: County and state agencies changed language on their intake and assessment forms, including questions about resilience. This new, positive framing, allowed agencies to see the strengths in the families they serve.

1. Kendall-Taylor, Nathaniel. (2012). The Resilience Scale: Using Metaphor to Communicate a Developmental Perspective on Resilience. Washington, DC: FrameWorks Institute.

WISCONSIN CHILD WELL-BEING INDICATORS (2017)

The OCMH is tasked with tracking the effectiveness of Wisconsin state agencies' child and family support and services and as such identified 48 child well-being indicators to measure and track children's mental, social, and emotional well-being from year-to-year.[3]

One goal in highlighting the 48 indicators is to promote the understanding that positive and negative influences impact children's development. Using the image of a scale, the reader can assess how a child is impacted by a balance of internal and external factors as well as positive and negative experiences.

- The scale symbolizes the concept that the more protective, positive experiences will tip the child toward resilience and overall positive outcomes.
- In contrast, more negative experiences, without the balance of resilience factors, tips toward negative outcomes.
- The placement of the scale's fulcrum represents the child's internal factors, such as genetics and disposition. The visual metaphor illustrates the theory that the more support children receive, the more hopeful their future.

Research on the long-term impact of adverse childhood experiences (ACEs) and protective factors provides data underlying this story of negative and positive influences. For example, a study seeking to determine the percentage of mental illness attributable to ACEs concluded, "the estimated proportions of poor mental health outcomes attributed to childhood adversity were medium to large for men and women."[4]

On the other side of the scale, researchers have begun to examine the role resilience plays in mitigating the negative impact of toxic stress. Initial findings suggest that there are protective factors, such as feeling supported by family, and that these early positive relationships help balance the impact of ACEs on negative adult outcomes.[5]

---

[3] For a full review of the indicators, please see the 2016 OCMH annual report.

[4] Afifi, T. O., Enns, M. W., Cox, B. J., Asmundson, G. J. G., Stein, M. B., & Sareen, J. (2008). Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated With Adverse Childhood Experiences. *American Journal of Public Health*, *98*(5), 946–952. http://doi.org/10.2105/AJPH.2007.120253

[5] Sege, R., Bethell, C., Linkenbach, J., Jones, J., Klika, B. & PEcorac, P.J. (2017). Balancing adverse childhood experiences with HOPE: New insights into the role of positive experience on child and family development. Boston: The Medical Foundation. Accessed on 9/20/17 at www.cssp.org

2017 Wisconsin Child Well-Being Dashboard: The 2017 dashboard contains updated data and highlights state and national trends. National and Wisconsin data are listed in two columns which indicate the value and compares 2017 to 2016 data. Bolded data highlights that the national average is improving. Some indicators have no trend arrow which indicates that the year-to-year differences were not statistically significant ($p<0.05$). The dashboard is a quick reference tool illustrating trends such as: 1) Wisconsin and the nation are moving in the right direction in increasing number of children in four-year-old kindergarten, 2) Wisconsin is seeing an unfortunate downward trend in the number of youth receiving treatment for depression, while on average children across the nation are more likely to get treatment, or 3) Wisconsin has fewer children in foster care, now with only 35.8 placements per 10,000 children.

Considerations: Much of the data did not change significantly from one year to the next. In some instances this may be the result of a small survey sample size or may reflect the slow process of change despite dedicated efforts.

Key Points: Wisconsin's positive trends include increased provider availability and a reduction in negative outcomes, such as youth arrests and teen births. Wisconsin outperformed the U.S. in a decreased trend in foster care placement. Wisconsin's youth homelessness is increasing while the U.S. as a whole reports a drop in youth homelessness.

Resilience, Risk, and Outcomes: How Wisconsin Stacks Up

Research on child development details how genes and the environment interact as children grow into adulthood. Individuals have different genetic starting points and experience different positive factors, such as resilience-building supports, and negative factors, such as Adverse Childhood Experiences (ACEs). The following indicators represent some of these factors, as well as interventions and potential outcomes.

	Indicator (Year)	National	Trend	WI	Trend
CHILDHOOD RESILIENCE	Early Childhood Screening ('16)	27.1%	▲	26.9%	
	Early Intervention Services for Infants and Toddlers ('14)	**3.0%**	▲	2.83%	
	Early Prenatal Care ('15)	71.7%	▲	**79.5%**	
	Eighth Grade Math Proficiency ('15)	32.0%		**41.0%**	
	Four-Year-Old Kindergarten Attendance ('15/'16)	32.0%	▲	**71.0%**	▲
	Neighborhood Safety (Parent Perception) ('16)*	63.8%	▼	**73.2%**	
	Parents with Higher Education Degrees ('15)	38.3%	▲	**44.8%**	
	Positive Adult Mentor ('16)	88.7%		**94.1%**	
	Spending on Health/Wellness Promotion ('15/'16)			$250 per resident	▲
CHILDHOOD RISK FACTOR	ACE: Death of Parent ('16)	3.3%		2.6%	
	ACE: Divorce ('16)	25.0%	▼	22.2%	
	ACE: Experienced Neighborhood Violence ('16)	3.9%	▲	4.4%	
	ACE: Experienced Racism ('16)	3.7%		3.5%	
	ACE: Jailed Parent/Guardian ('16)	**8.2%**	▼	9.1%	
	ACE: Lived with Someone who had a Problem with Alcohol/Drugs ('16)	9.0%	▲	8.5%	
	ACE: Parent/Relative with Mental Illness ('16)	7.8%		8.7%	
	ACE: Socioeconomic Hardship ('16)	25.4%		23.2%	
	ACE: Witnessed Domestic Violence ('16)	5.7%	▼	5.7%	
	ACE: Two or More ('16)	21.7%		20.3%	
	Cyber Bullying (US:'15/WI:'17)	**15.5%**		18.3%	
	Maternal Stressors During Pregnancy ('13)	28.8%	▼	31.9%	▼
	Poverty (Youth) ('16)	41.0%	▲	**35.0%**	▲
	Single Parent Households ('16)	35.0%		**32.0%**	
	Substantiated Child Abuse or Neglect ('15)	9.3 per 1,000	▲	**3.7 per 1,000**	▼

	Indicator (Year)	National	Trend	WI	Trend
INTERVENTIONS	Availability of Child, Family, School Social Workers ('16)	**94 per 100,000**	▲	60 per 100,000	
	Availability of Psychiatrists ('16)	7.7 per 100,000	▲	6.8 per 100,000	▲
	Availability of Psychologists ('16)	33.9 per 100,000	▲	37.5 per 100,000	▲
	Insurance Coverage (Youth) ('16)	95.0%		95.0%	
	Mental Health Hospitalizations ('13)¥	**199 per 100,000**		223 per 100,000	
	Receive Treatment for Depression ('11-'15)*	**38.9%**	▲	33.3%	▼
	Spending on Mental Health/Substance Use Treatment ('15/'16)			$705 per resident	
POSITIVE OUTCOMES	Employment Rate (Young Adults) ('16)	49.4%		**63.3%**	
	Flourishing Behaviors (Adolescents) ('16)*	40.4%		39.9%	
	Flourishing Behaviors (Children) ('16)*	64.6%		67.0%	
	High School Graduation Rate ('14/'15)	83.2%	▲	**88.4%**	▼
	Home Ownership (Adults) ('16)	70.0%		71.0%	
	Positive Mental Health (Adults) ('16)	82.6%		83.3%	
	Young Adults with Postsecondary Education ('16)	43.9%	▼	**47.7%**	
NEGATIVE OUTCOMES	Alcohol Use (Youth) (US:'15/WI:'17)	32.8%		30.4%	
	Foster Care Placements ('15)	35.9 per 10,000	▼	35.8 per 10,000	▲
	General Poor Mental Health (Youth) (US:'15/WI:'17)	**29.9%**		27.0%	
	Homelessness (Youth) ('14/'15)	**15.7 per 1,000**	▲	21.1 per 1,000	▼
	Illegal Drug Use (Youth) ('13/'14)¥	9.2%		9.3%	
	Juvenile Arrests ('16)*	**10 per 1,000**		32.5 per 1,000	▲
	Mental Illness (Youth) ('14/'15)	20.9%	▼	22.4%	
	School Suspensions & Expulsions ('16)			6.2%	▼
	Suicide Rate (Youth) ('11 to '15)	**5.6 per 100,000**	▼	7.5 per 100,000	
	Teen Birth Rate ('15)	22.3 per 1,000	▲	**16.2 per 1,000**	▲

* Metric changed from 2016 dashboard. Visit **children.wi.gov** for details.

¥ No update available.

Better(▲)/worse(▼) designation indicates statistically significant difference from previous year ($p < 0.05$).

Bolded metric represents a statistically better value compared to US or WI.

Wisconsin aims to tip the scale towards positive outcomes.
To learn more about each of these 48 Child Well-Being Indicators, please visit **children.wi.gov/Pages/Improve/Indicators.aspx**

WISCONSIN CHILD WELL-BEING FACT SHEETS

Fulfilling the OCMH requirement to monitor the performance of child and family serving programs requires the collection and analysis of service outcome data that is largely unavailable. The following fact sheets, in combination with the Wisconsin Child-Well Being Indicator dashboard, represent proxies for program outcomes; that is, the OCMH believes that if family service policies and programs are effective and aligned across service systems, data related to issues such as psychiatric hospitalizations, youth suicide, school engagement, child welfare, and youth justice will show improvement.

OCMH Fact Sheets

The fact sheets beginning on page 37 are intended to spur continued conversations about how children and families can best be served by Wisconsin's policies and programs; the sheets reflect only some of the complexities of the issues, the population served, or the services provided.

List of Fact Sheets

- Child Maltreatment and Out-of-Home Care
- Children's Demographics and Well-Being
- Children's Medicaid Funded Mental Health Services
- Crisis Intervention Services for Children on Medicaid
- Mental Health Provider Availability
- Mental Health Services in Schools
- Opioid and Methamphetamine Use
- Outpatient Mental Health Service Data for Children on Medicaid
- Psychotropic Medication Prescribing for Children on Medicaid
- Resilience
- School Outcomes
- Services for Children with Delays or Disabilities
- Youth Justice
- Youth Psychiatric Hospitalizations, Readmissions, and Emergency Detentions
- Youth Suicide and Self Harm

By limiting the fact sheets to one page, characteristics of the representative population are limited and in aggregate. The following information provides a brief description of some of the additional information that should be considered while reviewing the fact sheets.

Data Sources: The data for this report largely comes from the following sources: Youth Risk Behavior Survey[6] and the Behavioral Risk Factor Surveillance System;[7] the National Survey of Drug Use and

[6] Administered through the Wisconsin DPI and supported by the U.S. Centers for Disease Control and Prevention

Health[8] and the National Survey of Children's Health;[9] program specific data from Wisconsin's child and family serving state agencies; and Medicaid claims data.

National surveys and datasets allow comparisons between states and to the nation as a whole, but are based on samples, not the whole population. Statistical analysis allows for comparing values across time or across geographies, though sometimes the sample sizes are too small to say definitively if the Wisconsin value is different from the national value.

The Youth Risk Behavior Survey (YRBS) is issued to high school students across the country every two years and includes questions related to a variety of topics such as drug usage, nutrition, physical activity, and mental health. The YRBS reaches only youth who attend school which means that the remaining youth are not surveyed, such as the 3% of kids who are homeschooled[10].

The Wisconsin Behavioral Risk Factor Survey asks adult residents (18 and over) about many behaviors, including alcohol, drugs, mental health, and general health questions. Residents from every U.S. state are surveyed yearly.

Medicaid is a joint federal and state program that provides health coverage to children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid serves about half of Wisconsin's children and is the largest payer of children's mental health services. Medicaid claims data is currently the best resource available for identifying Medicaid spending, but there are limitations including the following:

- *Time lag:* Providers have 365 days to submit claims, so the earliest data available for analysis is for services provided in 2015. These claims do not reflect changes that have happened in the past two years such as increased mental health services in the schools.
- *Unclear service designation:* Sometimes it is not possible to identify the provider type and/or the service. As an example, claims data from school services does not always identify service type which may range from assessment to treatment.
- *Incomplete data:* Medicaid claims data do not provide information about children who need but are not receiving mental health services, nor does it represent children who receive services funded outside of Medicaid such as those provided by private insurance providers.

More on Medicaid: In order to participate in Medicaid, individuals must fall into federally defined categories such as having an income below the poverty level. Specifically analyzing Medicaid data leads to a focus on children living in poverty, which is only a subset of the general population. Poverty can impede children's learning and contribute to social, emotional, and behavioral problems – the greatest risk being to young children and/or children who experience deep and persistent

---

[7] Administered through the Wisconsin DHS and supported by the U.S. Centers for Disease Control and Prevention

[8] Administered by RTI International, supported by the Substance Abuse and Mental Health Services Administration

[9] Administered by the Child & Adolescent Health Measurement Initiative

[10] Redford, J., Battle, D., and Bielick, S. (2016). Homeschooling in the United States: 2012 (NCES 2016-096). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education. Washington, DC.

poverty.[11] More recently, research has identified that poverty may impact a child's developing biology. In one study, researchers found that parts of the brain related to academic performance were smaller for those children raised in very poor families.[12] In another study, child poverty rates were related to both adolescent emotional well-being and educational achievement across both the U.S. and other developed countries.[13]

Geographic Differences: In general, Wisconsin's urban and rural areas provide different levels of mental health support and services. Differences also exist on smaller scales within counties, cities, towns, and communities. Some county-level data differences are highlighted, though most are not.

Absence of Tribal Data: Tribes are sovereign nations and as such do not have local and state public health reporting requirements. Because census data does not consistently include information related to tribal members, researchers do not know how many individuals of native descent live in Wisconsin and thus cannot calculate the percent of tribal members who use particular services.

Multi-year (2011-2014) analysis of Behavioral Risk Factor Surveillance Survey data are often pooled together with results indicating higher lifetime depression for Native Americans versus all other racial groups. Correspondingly, the Indian Health Suicide Surveillance data indicates that suicide rates for Native youth is triple that of the U.S. rates.

The OCMH's future goal is to provide more Native youth data highlighting both the challenges and strengths within tribal communities. The OCMH will invite epidemiologists from the Great Lakes Inter-Tribal Epidemiological Center to join the OCMH Research Advisory Council as one small step in meeting this goal.

Population-Based Data is not Disaggregated by Sexual Identity, Race, Ethnicity, or Disability: The data represented in the fact sheets are in aggregate, meaning the differences among various populations are incorporated into the whole. As a result, the experience among sub-populations is not well represented. It should also be noted that these smaller populations often represent the children and families who would most benefit from improved policies, aligned systems, and better programs.

- *Sexual Identity*: National and statewide data indicate that school-age youth identifying as a sexual minority are two or three times more likely to be depressed, and consider, plan, or attempt suicide.[14] These data also show that gay, lesbian, or bisexual youth are twice as likely to feel unsafe at school and twice as likely to be electronically bullied.
- *Race and Ethnicity*: Some evidence indicates that Black and Hispanic youth are less likely to

[11] National Center for Children in Poverty. (n.d.). Child Poverty. Retrieved from www.nccp.org/topics/childpoverty.html

[12] Hair, N. L., Hanson, J. L., Wolfe, B. L., & Pollak, S. D. (2015). Association of child poverty, brain development, and academic achievement. JAMA pediatrics, 169(9), 822-829.

[13] Sznitman, S. R., Reisel, L., & Romer, D. (2011). The neglected role of adolescent emotional well-being in national educational achievement: Bridging the gap between education and mental health policies. *Journal of Adolescent Health, 48*(2), 135-142.

[14] Wisconsin Department of Public Instruction. (2017). *2017 Youth Risk Behavior Survey Results Wisconsin High School Survey Risk Behaviors and Sexual Identity Report* [Data table]. Madison, WI.

receive mental health services, even among youth with high needs.[15,16] While the prevalence of psychiatric conditions is considered similar across racial and ethnic groups, Black and Hispanic children receive significantly less behavioral health care than White children. In some cases, children of color who have mental health issues are misdirected into the juvenile justices system.[17]

By 2050, Hispanic school-aged youth in the U.S. are projected to outnumber non-Hispanic White peers. Currently, Hispanic youth represent the largest U.S. ethnic minority group and the largest group with unmet needs for mental health services.[18] For example, a national study found that Hispanic children had 49% fewer visits to psychiatrists and 58% fewer visits to any mental health professional than white children.[19]

- *Disability:* Some data (e.g. suspensions and expulsions) is disaggregated by disability but most is not. Historically, reporting on child abuse or neglect of children with disabilities has been under represented. As required by 2015 Wisconsin ACT 365, the Wisconsin Department of Children and Families reviewed data related to children with disabilities in the child welfare system. The data showed that children with disabilities face more maltreatment than children without disabilities, representing 27% of children with substantiated abuse, and 37% of children in out-of-home care.[20]

Lack of Strength-Based Data: Just as the lack of disaggregated data hides the unique struggles of certain groups, it also can mask the specific strengths of these communities and the gains that have been made. Positive psychology is the study of what is "right" about people—their assets and strengths. By focusing on positive attributes, individuals, communities, and societies shift to a "thriving" perspective which has been found to bolster psychological resilience and promote positive mental health.[21] Resilience Theory, a researcher's parallel to positive psychology, brings a new focus on positive factors in youths' lives. As this approach takes hold, more data on youth strengths and positive resources will become available, leading to increased understanding of the processes by which youth, despite experiencing hardship, are able to achieve.[22]

---

[15] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: a national study. International Journal of Health Services, 46(4), 810-824.
[16] Merikangas, K. R., et al. (2011). Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry, 50(1), 32–45.
[17] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016).
[18] Montañez, E., Berger-Jenkins, E., Rodriguez, J., McCord, M., & Meyer, D. (2015). Turn 2 Us: Outcomes of an urban elementary school–based mental health promotion and prevention program serving ethnic minority youths. *Children & Schools, 37*(2), 100-107.
[19] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: a national study. International Journal of Health Services, 46(4), 810-824.
[20] Wisconsin DCF. (2016). Report on Children with Disabilities Served by the Child Welfare System. Madison, WI. Retrieved from https://dcf.wisconsin.gov/files/cwportal/reports/pdf/act365.pdf
[21] Kobau, M., Seligman, M., Peterson, C., Diener, E., & Zack, M.(2011). Mental health promotion in public health: Perspectives and strategies from positive psychology. *American Journal of Public Health, 101*(8), E1-9.
[22] Zimmerman, M. A. (2013). Resiliency Theory: A Strengths-Based Approach to Research and Practice for Adolescent Health. *Health Education & Behavior : The Official Publication of the Society for Public Health Education*, *40*(4), 381–383. http://doi.org/10.1177/1090198113493782.

Wisconsin Office of Children's Mental Health

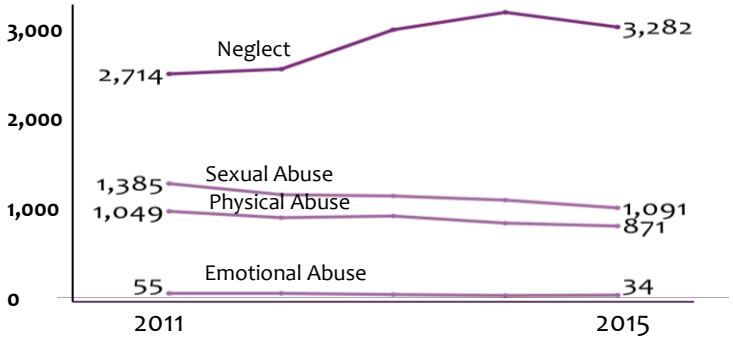
FACT SHEET: Child Maltreatment and Out-of-Home Care

The Wisconsin Child Welfare System aims to keep children safe, and to support families to provide safe, permanent, and nurturing homes for their children. Wisconsin does this by safely keeping children in their own home, family, tribe, and community whenever possible. When this is not possible, children are placed in safe, stable, and temporary homes to nurture and support children's development, with the goal of transitioning back to the family, or another permanent home. The system strives to engage with children, youth, and families to expand healthy connections and supports in their community and tribes and bolster resiliency in families to help them thrive.

Maltreatment[1]

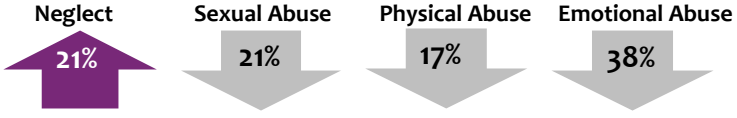
Children can be found to be victims of four categories of maltreatment: neglect, sexual abuse, physical abuse, or emotional abuse.

Substantiated maltreatment cases in Wisconsin by type (2015)



In Wisconsin, the most common form of maltreatment (62% of all cases in 2015) is neglect, defined as *"failure, refusal or inability on the part of a caregiver, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child."* [Ref. s. 48.02(12g), Wis. Stats.]

Statewide, from 2011 to 2015, the number of neglect cases increased, while the other forms of abuse decreased



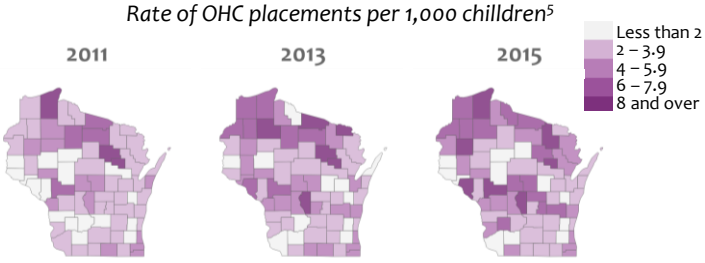
Key Findings

- In Wisconsin, the most common form of maltreatment is neglect.
- The number of children in out-of-home care increased steadily from 2012 to 2015, reaching its highest point in the last 10 years.
- Caregiver substance abuse is increasingly being identified as a reason for placement.
- The number of youth aging out of OHC in Wisconsin has declined since 2011.

Out-of-Home Care (OHC)

Statewide, 11,640 children were placed in OHC in 2015, an 8% increase from the ten-year-low in 2012.[2] The Wisconsin OHC rate was 3.9 per 1,000 children in 2015 (up from 3.5 in 2011), which is similar to the U.S. rate.[3,4]

Rate of OHC placements per 1,000 chilldren[5]

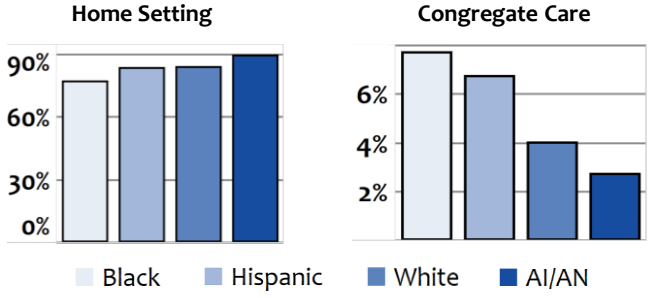


The OHC rate varies significantly by county. 80% of counties in the northern region, and 67% of those in the western region had higher than average placement rates.[6]

Placement Setting

When children are placed in OHC, placements with relatives are sought whenever possible. In Wisconsin, one out of three children in OHC are placed with a relative. In 2015, rates of placement with a relative were similar across all racial/ethnic groups. The percentage of children identified as Black or Hispanic who were placed with relatives increased 25% between 2012 and 2015.[7]

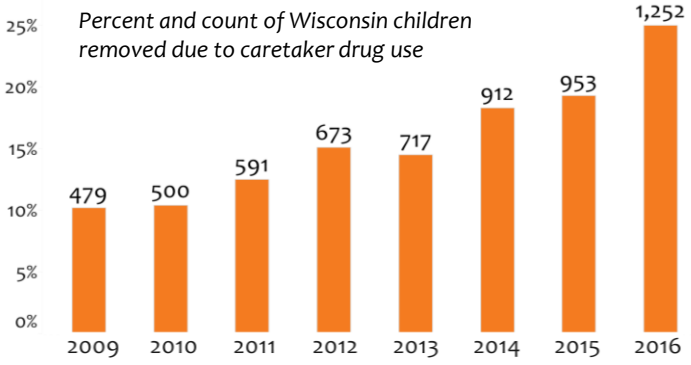
While there are times when group care is necessary to ensure a child's safety, most children and youth in OHC are best served in a home setting.[8]



In 2015, a higher percentage of American Indian/Alaskan Native children were placed in home settings than all other racial groups, while Black children had the highest percentage of congregate care placements.[9]

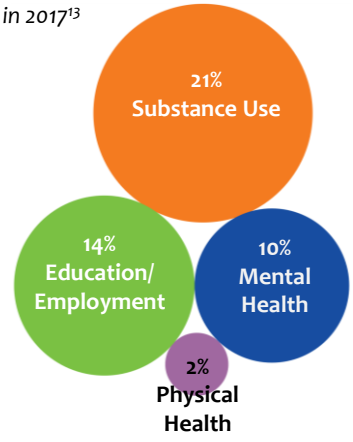
Parental Substance Use[10]

It is difficult to provide precise statistics on the number of families in child welfare affected by parental substance use or dependency, but two measures used are removal reason (captured at time of placement) and the level of parental need (evaluated throughout the child's OHC placement).



In 2016, **caretaker drug use** was listed as a removal reason for 25% of Wisconsin children, up from 10% in 2009. Children age 4 and under were the most likely to have this as a removal reason, but the percentage of those age 5-10 has increased, and in 2015 was nearly equal to that of the youngest children.[11]

Wisconsin significant parental need in 2017[13]



As of October 1, 2017, **substance use** and **mental health** were each listed as a parental need for 2 out of 3 OHC cases statewide, with substance use identified as a significant need in 21% of all cases.

In both the western and northern regions, **substance use** was listed as a significant parental need nearly three times more often than **mental health.**[12]

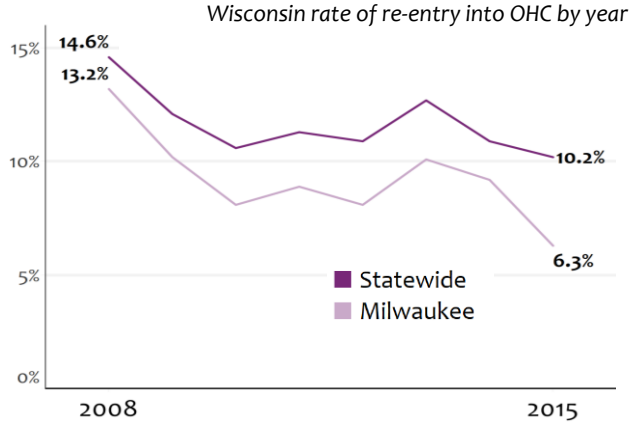
Permanence[14] (2015)

The median length of time in OHC per removal was 343 days, slightly lower than the national average of 378 days.[15] Older children have longer stays (median 632 days), as do Black children (median 385 days) compared to children of any other racial group. In Wisconsin, 64% of children who exit OHC are reunified with their parent(s), compared to 51% nationally.[16]

Re-Entry[17]

The rate at which children re-enter OHC within 12 months has been falling since 2008. One out of 10 children who were discharged from OHC statewide re-entered care within the next 12 months, down from 1 in 7. The rate has fallen more sharply for Milwaukee county to 1 out of 16 re-entering care.

Wisconsin rate of re-entry into OHC by year



Aging Out

When youth exit the foster care system without achieving permanence (either through reunification, guardianship, or adoption), they are said to have "aged out." These youth often face more significant struggles than their peers, including higher rates of incarceration, pregnancy, economic hardship, and substance dependency and lower educational attainment.[18] The number of youth aging out of OHC in Wisconsin has declined by 38% since 2011 (462 in 2011 to 285

References

1. WI Department of Children and Families. (2016). *Wisconsin Child Abuse and Neglect Report 2015*. Retrieved from https://dcf.wisconsin.gov/files/cwportal/reports/pdf/can.pdf
2. WI Department of Children and Families. (2016). *Wisconsin Children in Out-of-Home Care 2015*. Retrieved from https://dcf.wisconsin.gov/files/cwportal/reports/pdf/ohc.pdf
3. IBID
4. Child Trends. (2016). *Wisconsin Foster Care for Federal Fiscal Year 2015*. Retrieved from https://www.childtrends.org/publications/foster-care-facts-in-wisconsin/
5. DCF. *Wisconsin Children in Out-of-Home Care 2015*.
6. Data from WI Department of Children and Families Out of Home Care Reports, years 2011-2015. Retrieved from https://dcf.wisconsin.gov/reports
7. IBID
8. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2015) *A National Look at the Use of Congregate Care in Child Welfare*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf
9. DCF. *Wisconsin Children in Out-of-Home Care 2015*.
10. WI Department of Children and Families, 2009-2016. Personal communication from 10/27/2017.
11. Data from WI Department of Children and Families Out of Home Care Reports, years 2011-2015.
12. WI Department of Children and Families. Child and Youth Needs – Parental Needs Dashboard. Accessed 10/29/2017. https://dcf.wisconsin.gov/reports?accactive=1
13. IBID
14. DCF. *Wisconsin Children in Out-of-Home Care 2015*.
15. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2016). *The AFCARS Report: FY 2015*. Retrieved 11/13/2017 from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport23.pdf
16. Child Trends. (2016). *Wisconsin Foster Care for Federal Fiscal Year 2015*.
17. Department of Children and Families. (2016). *Wisconsin Children in Out-of-Home Care 2015*.
18. Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., Vorhies, V. (2011). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 26*. Retrieved from: http://www.chapinhall.org/sites/default/files/Midwest%20Evaluation_Report_4_10_12.pdf
19. Department of Children and Families. Aging Out Dashboard. Accessed 10/11/2017. https://dcf.wisconsin.gov/reports?accactive=1

Wisconsin Office of Children's Mental Health

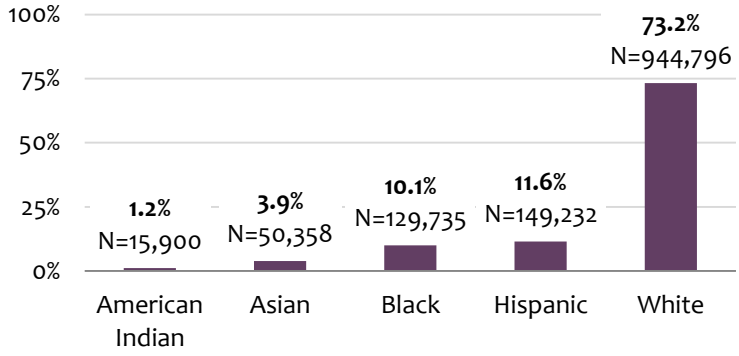
FACT SHEET: Children's Demographics and Well-Being

Population (2016)

Total Wisconsin population: 5,774,977

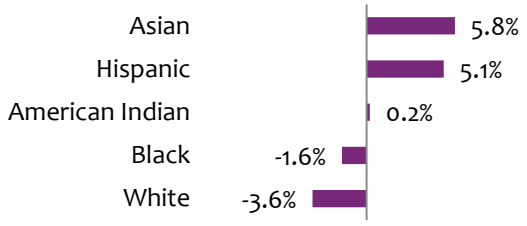
- Black residents make up 6.8% of the total population.
- Hispanic population in Wisconsin is 387,379, about 6.7% of the total.
- White residents make up 82.5% of the population.

Diversity within Wisconsin's child population (2016)



The Wisconsin population is changing, with an increase in the percent of children in Wisconsin who are Asian and Hispanic.

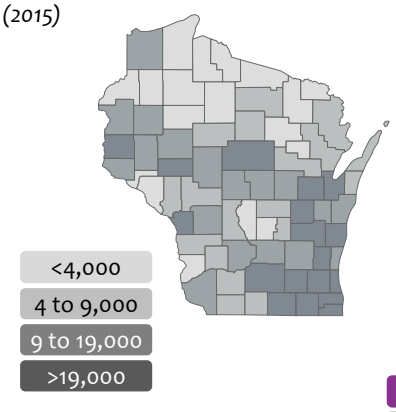
Child demographic change between 2012 and 2016 in Wisconsin.



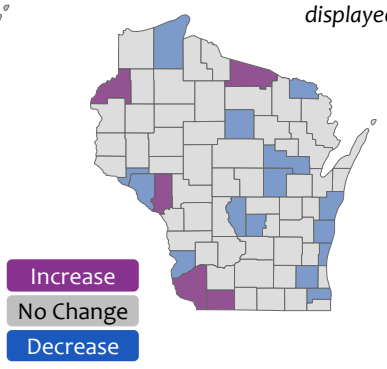
Geography

The majority of the children live in the Southeast region (38%), and 31% live in rural counties with fewer than 20,000 people.

Wisconsin county population, ages <18 (2015)



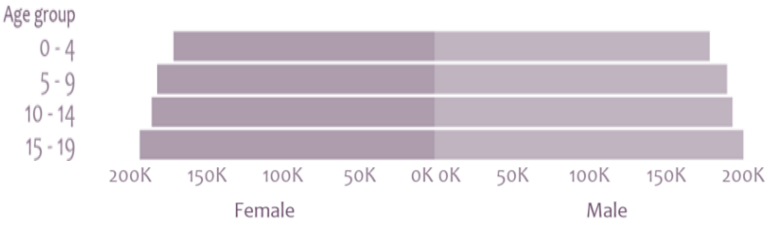
Changes in county child population from 2011 to 2015. Changes over 10% up or down are displayed.



Child population (0-18) was 1,290,021 , about 22% of the general population in 2016.

- Black children make up 10.1% of the child population.
- Hispanic children make up 11.6%.
- White children make up 73.2% of the Wisconsin child population.

Wisconsin's population by age and gender (2015)



Wisconsin is 12th Overall in National Health Rankings (Kids Count)

Contributing Factors

- Strong economic well-being, with fewer parents lacking employment, and fewer children in poverty.
- High marks in education, such as more young children in school, better math proficiency, and more students graduating high school on time.

Wisconsin ranks 42nd in the nation in youth mental health (Mental Health America)

Contributing Factors

- High depression rates
- Low treatment for youth with mental illness

Of note: Wisconsin ranks ranked 11th for adult mental health.

Wisconsin ranks 15th in the nation in best overall health for women and children (American Health Ranking)

Contributing Factors

- High rate of insured children.
- Low food insecurity.
- Excellent health care available for women, particularly pregnant women.

Of note: Wisconsin ranks ranked 21st for infants' health and 15th for children's health.

Demographics and Well-Being (page 2)

Wisconsin's Families

Family Stability
- The median household income in Wisconsin in 2016 was $59,817, comparable to national and Midwest medians.
- One of five of Wisconsin's children lived in of poverty.
- In 2016, 73% of children ages 6-12 have all parents working outside the home.

Community and Connection
- 85.1% of Wisconsin's children had stable housing, e.g., lived in the same house as one year ago.
- More Wisconsin children (48.6%) participated in community service than the national average (43.1%).

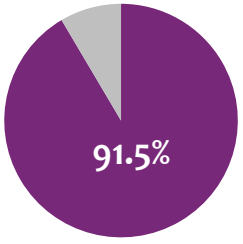
Adult Health
- 93% of Wisconsin adults have health insurance.
- 9 in 10 adults report good health.
- 1 in 10 adults received mental health services in 2015.
- 4% of adults reported having a serious mental illness, and 6.6% reported major depression in 2015.

Health

Health Care
- 83% children visited a doctor for a check-up in 2015.
- Most children (91%) received family-centered care.

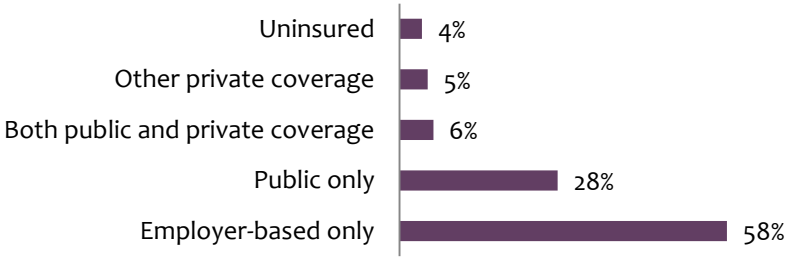
Insurance
- Over 95% of Wisconsin children were covered by insurance in 2016.
- 45% of children ages 0-18 were covered by Medicaid throughout 2015.
- Wisconsin spends the least amount of money per child on Medicaid, at $1,656/child/year compared to the Midwest. The average in the US is $2,492/child/year.

Most Wisconsin children are in excellent health



Similar to national average

Percent of Wisconsin children by insurance type (2016)



Mental Health
- 21% of Wisconsin children have any mental health issue (right).

Anxiety	1	in	11
Behavioral/Conduct	1	in	14
Depression	1	in	20
Ongoing EBD	1	in	11
Any Mental Illness	**1**	**in**	**5**

Physical Health
- 1 in 3 youth ages 10-17 are overweight or obese.
- Kindergarten through 6th grade get a minimum of 3 physical activity classes per week in school.
- 59% of Wisconsin's children ages 6-17 report 60+ minutes of exercise, 4+ days/week.

Education

Children
- 863,381 children attended school in 2016/17.
- In 2015/16 64% of four-year olds attended kindergarten.
- 59% of high schoolers enrolled in postsecondary education in 2015/16.
- 13,300 students were Identified with Emotional/Behavioral disturbance for an Individualized Education Program (IEP), 1.5% of all enrolled students and 11% of students with disabilities.

Adults
- 91% of Wisconsin adults over 25, on average, had a high school degree (2011-2015).
- 40% of adults have an associates, bachelor or higher degree.

Wisconsin Office of Children's Mental Health

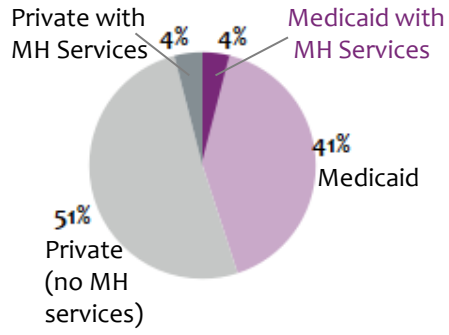
FACT SHEET: Children's Medicaid Funded Mental Health Services

Medicaid. In Wisconsin, the Medicaid program is more commonly known as BadgerCare or Title 19. BadgerCare Plus refers to the part of Wisconsin's Medicaid program which insures children, children in foster care, children receiving Social Security Income (SSI),[1] and low-income or disabled adults. Within the OCMH fact sheets, we use the term Medicaid.

Children, Medicaid, and Mental Health Services (2015)

- Medicaid covers approximately half of Wisconsin's 1.3 million children; the remaining children are covered by private (employer-sponsored) insurance, leaving 5% of Wisconsin's children uninsured.[2]
- 9% (54,770) of children on Medicaid (around 600,000 throughout 2015) received Medicaid-funded mental health services (therapy, psychiatric hospitalizations, or other treatments); this represents 4% of the Wisconsin child population.[3]
- An estimated 21% of Wisconsin's children have any mental illness. Some children receive mental health services through other public systems or through private insurance (~4% of Wisconsin children),[4] but there still remains a treatment gap of about 34% of children.[5]
- Children with mental/behavioral issues on average receive approximately the same rates of treatment whether covered by Medicaid or private insurance (52.9% vs. 52.6%).[6]
- Racial/ethnic data is missing for about 20% of the Wisconsin children on Medicaid, but of those with a race/ethnicity listed, 64% are white, 17% Black, 15% Hispanic, 4% Asian, Native American, or Alaskan.[7]
- 55% of youth recipients of mental health services are male and 45% are female. Males tend to receive most services earlier (between 8 and 11 years old) while females receive the majority of services in adolescence (between 13 and 17 years old).[5]

One out of 25 Wisconsin children receives ***Medicaid reimbursed mental health services***



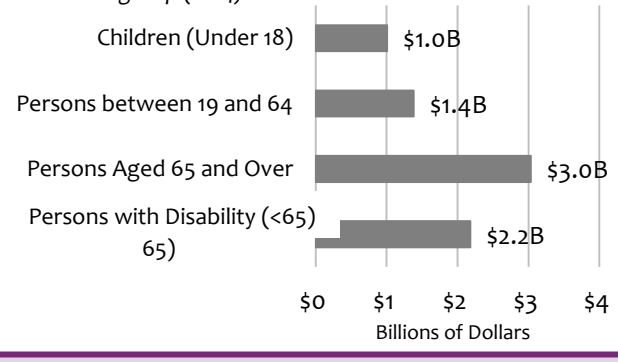
Medicaid Spending[8]

Medicaid services are paid 40% by the state, and 60% by federal dollars. In 2015, $94 million was spent on children's Medicaid mental health services in Wisconsin.

Total spending on children's mental health in 2014 was:

- 7% of the $1B spent on children
- 1% of the 7.6B spent on Medicaid overall

Wisconsin (state + federal) Medicaid spending by enrollment group (2014)

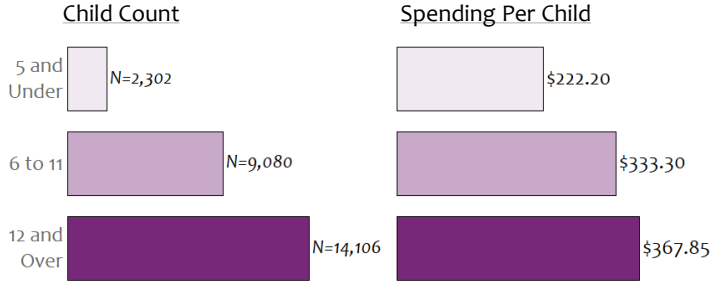


Cost per Child[9]

Medicaid payed an average of $318 per child in 2015 for mental health services, up 14% from 2014.

- The amount per child varied by county ranging from under $100 to $700 per child in a single year.
- Amount per child varied by age, with Medicaid paying more for older children (below).

Child count and average Medicaid mental health spending per child by age group in Wisconsin (2015)



Key Findings

- Only 1% of the Medicaid budget is spent on children's mental health services.
- 10% of children on Medicaid received Medicaid-funded mental health services, representing 4% of Wisconsin's children.
- There are many Medicaid funded children's mental health services. Ideally, children and families would receive community based, lower cost services prior to engaging in hospitalizations and other high-intensity, high-cost services.

Children's Medicaid Funded Mental Health Services (page 2)

Medicaid covers a variety of mental health services. The continuum ranges from outpatient therapy, to intermediate services such as crisis stabilization, and finally hospitalizations for acute care.[10] Focusing on outpatient and in-home services, with more intermediate services as needed, may support keeping children in their home and prevent psychiatric hospitalizations and residential care.[11]

Outpatient and In-Home Therapy
- 47,776 children
- $333 per child
- $45 to $150 per visit

Provided by psychiatrists, counselors, therapists, or social workers

Intermediate Services
- 13,614 children
- $3,343 per child
- Between $71 and $108 per day

Crisis services in or out of a hospital setting (daytime only) and comprehensive supports

Psychiatric Hospitalizations
- 3,030 children
- $7,209 per child
- $786 per day
- $4,600 per visit

Voluntary or involuntary hospitalizations for children with acute needs

Parent and Youth Voice[12]

Parents are grateful for access to Medicaid services that are not income-based, allowing their children to receive services not provided by private health insurance such as psychosocial rehabilitative services.

Parents report that Medicaid funds a wider range of community-based services than does private insurance.

By changing mental health prior authorization regulations, families report that Wisconsin Medicaid administrators facilitated easier, more timely access to services.

References

1. Approximately half of children on SSI qualify under mental health-related diagnoses. National Academies of Sciences, Engineering, and Medicine. (NASEM) *Mental disorders and disabilities among low-income children*. National Academies Press, 2015.
2. Kaiser Family Foundation. (2017). *Monthly Child Enrollment in Medicaid and CHIP.* State Health Facts, March 2017. Retrieved 7/12/2017 from kff.org.
3. Wisconsin Department of Health Services. (2015). Medicaid claims spending [Data file]. Received 3/1/2017 from the Division of Medicaid Services.
4. Wisconsin Health Information Organization. (2015). *Mental Health Claims Data* [Data file]. Retrieved 5/9/2017.
5. Department of Health Services, Division of Care and Treatment Services. (2017). *Wisconsin Mental Health and Substance Use Needs Assessment*. Madison, WI. (In Press).
6. National Survey of Children's Health. (2016). *Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health* [Data file]. Retrieved 9/21/2017 from www.childhealthdata.org.
7. Wisconsin Department of Health Services. (2012-2015). *Medicaid claims spending* [Data file]. Received 3/1/2017 from the Division of Medicaid Services. "Mental health services" are classified as having a mental health procedure code and a mental health diagnosis in the first or second diagnosis line on the claim. Comprehensive Community Services and Crisis Intervention are defined only by procedure code.
8. Kaiser Family Foundation. (2014). *Medicaid Spending by Enrollment Group.* State Health Facts, 2014. Retrieved 8/22/2017 from www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/.
9. Wisconsin Department of Health Services. (2012-2015). *Medicaid claims spending* [Data file]. Received 3/1/2017 from the Division of Medicaid Services.
10. IBID. Per child and per visit costs reflect the median paid in 2015. Per day costs reflects the total number of days utilized divided by the total cost.
11. Segal, S. P., & Burgess, P. M. (2008). Use of community treatment orders to prevent psychiatric hospitalization. *Australian & New Zealand Journal of Psychiatry*, 42(8), 732-739.
12. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov/.

Wisconsin Office of Children's Mental Health

FACT SHEET: Crisis Intervention Services for Children on Medicaid

Medicaid Reimbursed Crisis Intervention Services

Most of Wisconsin's 72 counties are certified under DHS 34 to provide crisis intervention. These services are available 24/7 to help resolve mental health and/or alcohol/drug crises. Services include a 24/7 telephone crisis line; 8-hour/5-day per week walk-in services; and 8-hour/7-day per week mobile crisis services to specific locations during specified times.

Wisconsin certified crisis services must comply to the standards in DHS 34, Wis. Admin. Code. Crisis Intervention Services including the following:

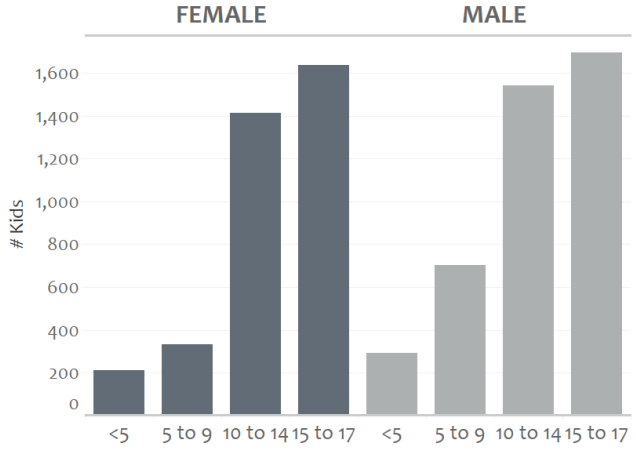
- Initial contact and determination of need by qualified mental health personnel,
- Initial mental health assessment and response planning,
- Referral and follow-up services such as therapy or day treatment,
- Optional crisis stabilization services.

Wisconsin's 2017/19 budget includes funding to expand youth crisis stabilization service capacity by creating a treatment facility which will be designed to prevent or de-escalate a young person's mental health crisis.

Crisis Intervention by Age and Gender

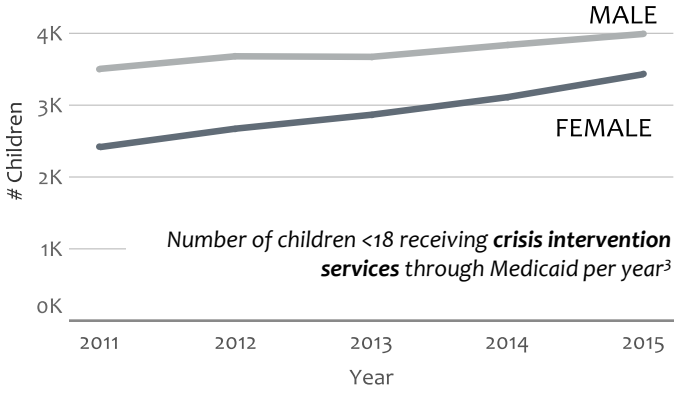
Most crisis intervention is provided to young people between 15 and 17 years of age, though 10-14 year olds are a close second.

Number of children on Medicaid using Crisis Intervention Services in 2015 by age group and gender[3]



Crisis Intervention

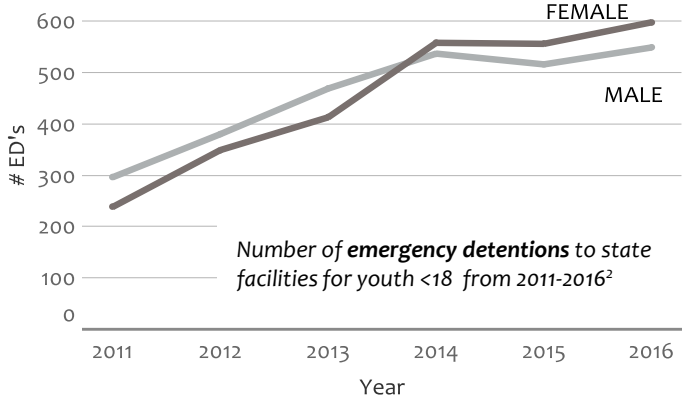
The number of children receiving crisis intervention has increased from 5,900 in 2011 to almost 7,500 in 2015. Across the four years, this is an increase of about 25% total (5-8% increase each year). The total cost of crisis intervention was almost $14M in 2015, up 40% from 2013 spending.



*Number of children <18 receiving **crisis intervention services** through Medicaid per year*[3]

Youth Emergency Detentions

Effective crisis intervention reduces the need for youth psychiatric hospitalizations and emergency detentions. The line graphs below and to the left represent the increases in both services. Data identifying the number of children diverted from an emergency detention due to crisis intervention is not currently collected.



*Number of **emergency detentions** to state facilities for youth <18 from 2011-2016*[2]

Key Findings

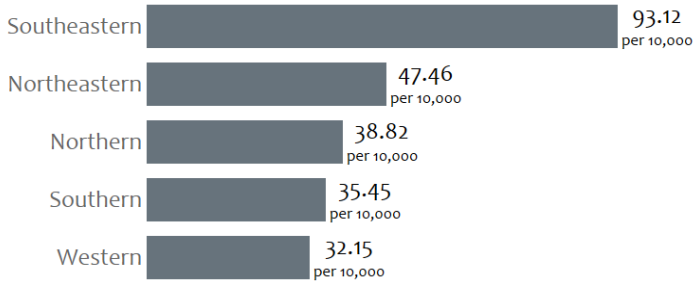
- Wisconsin has more youth using crisis intervention services each year, with 25% more children in 2015 than in 2011.
- Youth ages 15 to 17 are most likely to use crisis services.
- The southeast region provides crisis services at a rate twice as high as the rest of the state.
- The southern region provides more crisis services per child.

Crisis Intervention Services (page 2)

Regional Differences in Crisis Intervention Services

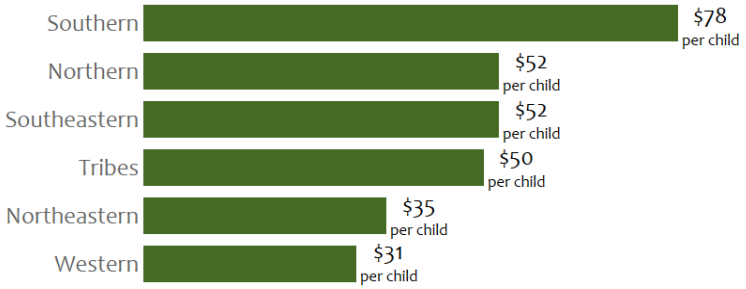
The southeastern region, encompassing Milwaukee and neighboring counties, has the highest rate of crisis intervention, with 93 per 10,000 children in the county receiving services (below).

Across Wisconsin, 44 per 10,000 children <18 receive crisis intervention under Medicaid, but rates vary by region[3]



The southern region, including Dane and Rock counties, provides the most crisis intervention per child, that is, children receiving crisis intervention in the southern region have more visits or visits of longer duration.

Average Medicaid spending on crisis intervention per child, per region of the state in 2015[3]



Parent and Youth Voice[4]

Families prefer when crisis intervention services are provided in the home, school, or community vs. a clinic or emergency room.

Families appreciate that crisis intervention services often provide a bridge to county and state supports through a crisis intervention plan.

In some communities, follow up to the crisis plan would be improved by adding "warm handoffs," that is, making an introduction to a provider instead of sending a family home with a list of names and phone numbers.

Children's Emergency Detention and Crisis Stabilization Workgroup

In 2014, Wisconsin state agencies initiated a workgroup to reduce the high rates of emergency detention. The group has grown over the years and now includes a Collective Impact Parent, more state agencies, providers, and county staff. Three sub-workgroups work on specific topics:

1. Best practices in supporting children in crisis,
2. Crisis stabilization bed availability,
3. County staff training requirements, structure, and delivery.

References

1. Wisconsin Legislature. (2010) Chapter DHS 34. Emergency Mental Health Services Programs. *Department of Health Services.* Madison, WI. Retrieved 10/10/2017 from *https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34*.
2. Wisconsin Department of Health Services, Division of Care and Treatment Services. (2011-2016). *Admission records for Winnebago Mental Health Institute* [Data file]. Received 6/9/2017.
3. Wisconsin Department of Health Services. (2012-2015). *Medicaid claims spending* [Data file]. Received 3/1/2017 from the Division of Medicaid Services. Claims for this analysis include children <18 receiving Crisis Intervention (procedure codes S9484 or S9485), from 2011-2015, with any diagnosis.
4. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

FACT SHEET: Mental Health Provider Availability

Mental Health Provider Availability for Adults and Children[1]

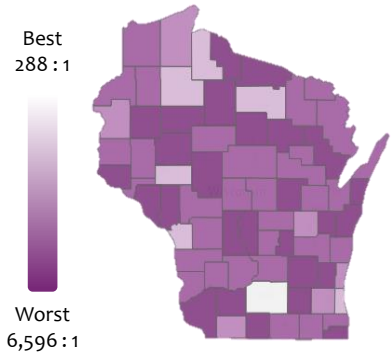
By 2025, the United States will face a 20% mental health provider shortage including social workers, therapists, and psychiatrists.[2] Wisconsin's rural communities are projected to experience the biggest impact.[3]

Geographic Impact[4]

Rural Wisconsin has almost half as many mental health providers as urban Wisconsin.

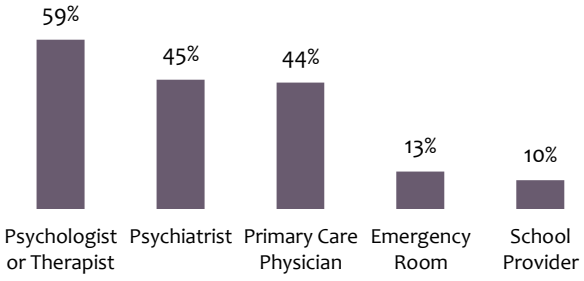
Rural	Urban
For every hundred residents in rural Wisconsin there are approximately **11 mental health professionals.**	For every hundred residents in urban Wisconsin there are approximately **19 mental health professionals.**

Ratio of population to mental health providers[5]



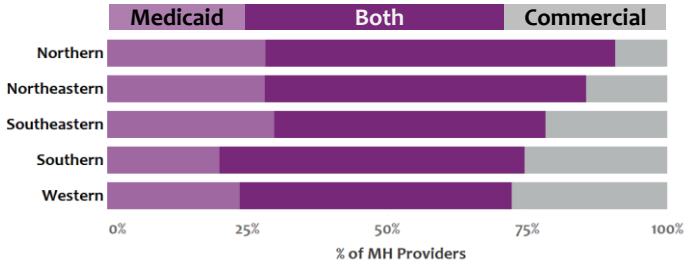
Provider Type[6]

Wisconsin residents primarily see a psychologist or therapist, psychiatrist, or a primary care provider (see bar graph below). Individuals may see more than one provider.



Insurance Coverage: In addition to geography, insurance type impacts access to providers. 71% of providers in 2015 accepted Medicaid (exclusively, or along with commercial insurance) with varying availability across regions.

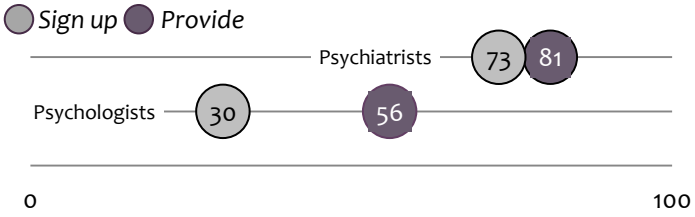
Percent of regional providers who provided services to patients with commercial or Medicaid insurance coverage[7]



Mental Health Providers and Medicaid[8]

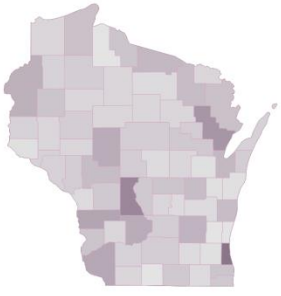
In Wisconsin in 2014:

- 30% of psychologists signed up to receive Medicaid clients, and 56% saw Medicaid clients
- 73% of psychiatrists signed up to receive Medicaid clients and 81% saw Medicaid clients

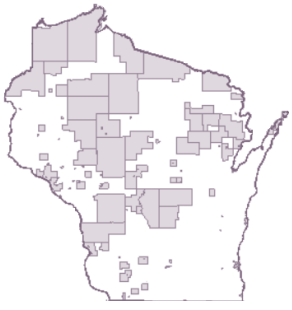


Wisconsin has a total of 134 Mental Health Professional Shortage Areas including a large area where the population is medically underserved (all specialties), particularly in the north western region.[9]

Mental health professional shortage areas (2017)



Medically underserved populations (2017)



Key Findings

- Rural Wisconsin has an overall provider shortage which includes mental health providers.
- Primary care physicians play a significant role in mental health provision.
- Wisconsin's northern region has the most providers who accept Medicaid compared to the western region where fewer providers accept Medicaid.
- Most psychiatrists in Wisconsin register for and provide services to Medicaid clients.

References

1. Data is not available to identify providers specifically for children in most databases.
2. US Department of Health and Human Services. (2016). *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025.* Retrieved 8/7/2017 from bhw.hrsa.gov.
3. Sugden, Nancy. (2015). *Projection of Physician Supply and Demand in Wisconsin through 2025*. Area Health Education Center, UW School of Medicine and Public Health. Retrieved 8/7/2017 from ahec.wisc.edu/.
4. Office of Rural Health. (2017). *Rural Wisconsin Health.* Retrieved 8/7/2017 from http://worh.org/.
5. Wisconsin Rankings. (2016). *County Health Rankings,* [Data file]. Retrieved 8/20/2017 from www.countyhealthrankings.org.
6. Wisconsin Family Health Survey, Department of Health Services. (2017). *Mental Health in Wisconsin.* Retrieved 5/18/2017 from https://www.dhs.wisconsin.gov/stats/fhs-mentalhealth-infographic.htm.
7. Wisconsin Health Information Organization. (2015). *Claims data for health plans in Wisconsin* [Data file]. Retrieved 5/10/2017 from https://impactintelligence.optum.com/whio. Data represents providers serving children specifically.
8. Wisconsin Medicaid Program. (2016). *Medicaid Plan for Monitoring Access to Fee-for-Service Health Care,* Publication P01565. Madison, WI. Includes the providers who are licensed under the Wisconsin Department of Safety and Professional Services.
9. Health Resources and Services Administration (HRSA). (2017). *Medically Underserved Populations* [Data file]. Retrieved 9/22/2017 from https://datawarehouse.hrsa.gov/.

Wisconsin Office of Children's Mental Health

FACT SHEET: Mental Health Services in Schools

Support for All Students: Student Services Staff in K-12 Schools

All students have the option to meet with school counselors, psychologists, social workers and nurses in individual or group counseling sessions. Mental health services in the schools address barriers to access and promote good outcomes.[1,2] Wisconsin does not collect statewide data on the number of sessions provided by the 4,455 student services staff.[3]

Additional activities promoting positive mental health:

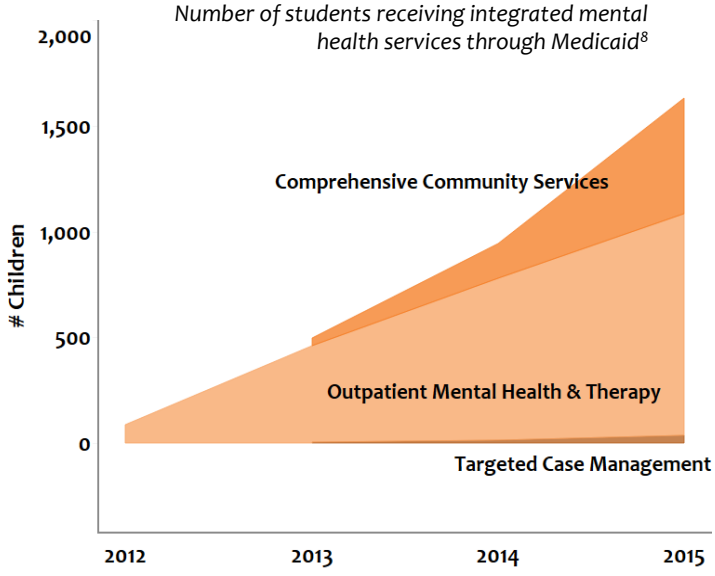
- Positive Behavioral Interventions & Supports
- Screening, Brief Intervention, Referral to Treatment (S-BIRT)
- Trauma Sensitive Practices

Staff	Activities[4]	WI Ratio[5]	Ideal Ratio[6]
School Counselor	• Provide counseling • Provide academic/career planning • Consult with teachers/school staff	458:1	250:1
School Psychologists	• Administer psychological assessments • Support diverse learning/emotional needs • Implement school-wide mental health policies/practices	979:1	600:1
School Nurses	• Connect families with community resources • Partner on treatment plans and assist in addressing mental health challenges	1,832:1	750:1
School Social Worker	• Advocate for students and families • Provide counseling • Consult with teachers/school staff	1,561:1	250:1

Counseling and Supports

Medicaid pays for many services delivered by community providers in the school setting.[7]

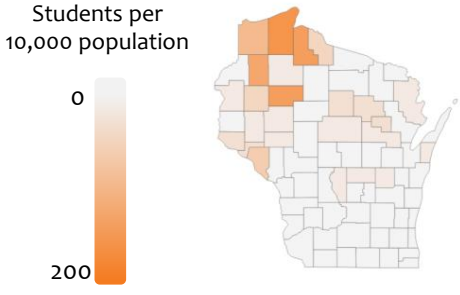
Number of students receiving integrated mental health services through Medicaid[8]



In the 2015/16 school year, Medicaid changed regulations related to mental health clinics and independent clinicians providing outpatient mental health services in schools resulting in enhanced school/mental health clinic collaborations.

Three times as many students were served by community providers integrated into schools in 2015 compared to two years earlier.

Number of students per capita receiving mental health therapy in schools (2015)[9]



Not included in data: Students with private insurance or mental health services funded by philanthropies and foundations.

Key Findings

- School counselors, school nurses and school social workers are underrepresented in Wisconsin schools.
- Statewide school-based mental health services are not tracked.
- Three times as many students were served by community providers integrated into schools in 2015 compared to two years earlier.
- School-based mental health makes up a small percentage (<5%) of outpatient therapy and many counties have no schools offering these services (see Fact Sheet: Outpatient Mental Health Service Data for Children on Medicaid).

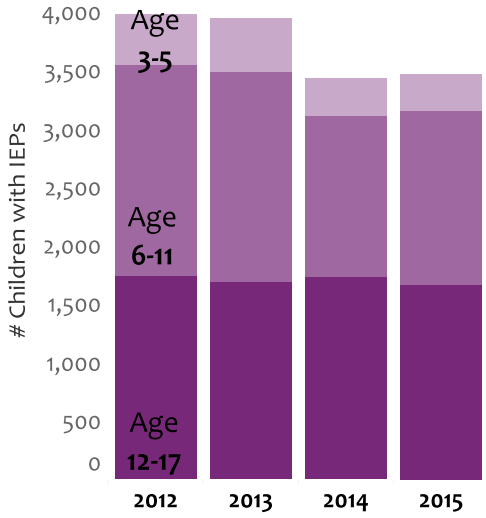
Mental Health Services in Schools (page 2)

Medicaid-Funded School-Based Services[10]

Medicaid pays for assessment and counseling specifically for children with Individualized Education Plan (IEPs). Services are jointly paid for by federal Medicaid (60%) with the school or district paying the state Medicaid portion (40%), unlike other services where state funds are used. Wisconsin pays $340,000 on average per year for these school-based services, a figure that has decreased since 2012.

A few school districts regularly use this funding mechanism, but most do not. The number of children receiving Medicaid reimbursed IEP services decreased from 2012 to 2015. Additional training for staff and school leadership could increase schools' ability to use these funds to increase access to services.

Number of children receiving Medicaid-reimbursed mental health IEP services by year[11]



★ **Good News!** School based mental health received $6 million for school mental health initiatives funding in the 2018-2019 Wisconsin budget. ★

School Social Workers and Children's Mental Health[12]

A 2016 Wisconsin survey of 555 school social workers showed:

- School social workers identify mental health as their top responsibility.
- 27% have specialties in mental health or clinical practice.
- Over half of school social workers spend <30% of their time on special education, other time is spent addressing students' victimization, attendance issues, family challenges, juvenile justice, etc.
- Social workers are distributed across all grades and many report working at multiple grade levels (see below).

Percent of social workers working in each grade level

Family and Youth Voice[13]

While some parents and caregivers appreciate the convenience of mental health services in schools, others worry that school-based services will prevent them from being involved in planning and treatment.

Some parents express frustration knowing that some schools offer mental health services while their children's schools do not.

References

1. Committee on School Health. (2004). School-based mental health services. Pediatrics, 113(6), 1839-1845.
2. Wolters Kluwer Health. (2017). *Mental health programs in schools: Growing body of evidence supports effectiveness.* ScienceDaily. Retrieved from www.sciencedaily.com/releases/2017/08/170810173331.htm.
3. WI Department of Public Instruction. (2016). *Schools at a Glance.* Madison, WI. Retrieved 11/7/2017 from https://dpi.wi.gov/wisedash/about-data/staff.
4. Wisconsin Department of Public Instruction. (2017). School Social Work Roles. Received from DPI 10/31/2017. All providers fulfil many duties, some of which are not listed here. More information found at https://dpi.wi.gov/sspw/pupil-services.
5. WI Department of Public Instruction. (2016). *Staff by Ethnicity and Gender Report Statewide* [Data file]. Retrieved 11/7/2017 from dpi.wi.gov.
6. Bush, Kathryn. (2014). *School Based Mental Health Services: A Wisconsin Update*. Presentation for the Wisconsin Children and Youth Committee, 10/2/2014. Madison, WI.
7. Wisconsin Department of Health Services. (2012-2015). *Medicaid claims spending* [Data file]. Received 3/1/2017 from the Division of Medicaid Services.
8. IBID. Includes outpatient mental health therapy in the location "School". "Comprehensive Community Services" is a program for individuals needing ongoing mental health or substance use services. "Targeted Case Management" provides funding for services that assist in gaining access to services, including assessment and development of a care plan.
9. IBID
10. IBID. Medicaid pays for procedure code T1024, modifiers U1-U8, "School-based services: Assessment, IEP, and psychological services" for children with an IEP.
11. IBID
12. Wisconsin Department of Public Instruction. (2016). *Longitudinal analysis of school social work practice in Wisconsin: Wisconsin school social worker survey – 1998-2016.* Madison, WI.
13. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

FACT SHEET: Opioid and Methamphetamine Use

Adverse Childhood Experiences (ACEs), Stress, and Drug Use

Experiences in Childhood:

- Children who are *sexually abused* are nearly five times more likely to inject drugs in adulthood as those who are not while children who witness violence are about three times more likely.[1]
- *Neglect, emotional abuse, parental incarceration, and parental binge drinking* were associated with 25-55% increased odds of prescription pain reliever misuse.[2]

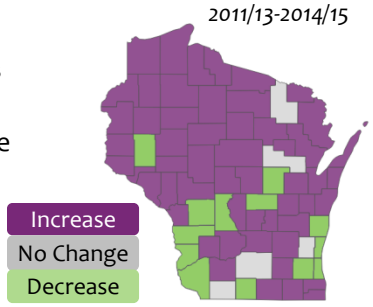
Stress in Adulthood:

- Parents report that opioids provide relief from emotional distress.[3]

Methamphetamine (Meth) Use

- Meth use has well-documented negative effects on families and communities. Communities with high usage see increased violence, domestic abuse, and social isolation. Communities also see a high economic burden due to increased health care costs and lost wages.[4]
- Nationally, in 2016, 69,000 12-17 year olds (<1%) and 14,464,000 adults over 18 (6%) had ever used meth.[5]
- Wisconsin meth arrests, charges, and seizures have tripled since 2011, with greatest increases occurring in rural areas (see map).[6]

Average change in meth cases between 2011/13-2014/15



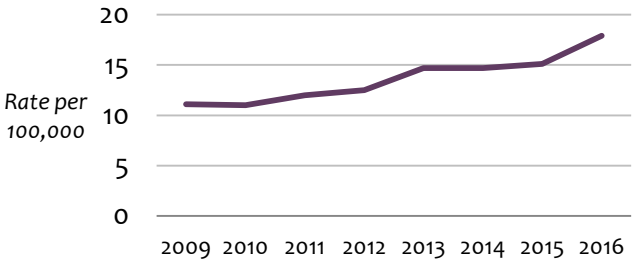
Opioid Use in the United States[7] (2015)

- 60% of the 55,000 drug overdoses in the U.S. were opioid-related.
- 10.4 per 100,000 persons in the U.S. died of opioid-related drug overdoses. The death rate was higher in males, individuals between 25-34, and non-Hispanic White people.
- In 2015, 5% of Americans over 12 years old misused opioids, with highest misuse among 21 -25 year olds at 9.4%. Opioid misuse dropped in 2016 with 4.4% of the total population using, and 7.6% of 21-25 year olds.[8]

Opioid Use in Wisconsin

- Rates and dosage of opioid prescriptions have decreased from 2014 to 2016. In 2016, Wisconsin's prescribing rate (62.2 prescriptions per 100 people) was lower than the national average (62.6/100 people) though rates of opioid prescriptions differ by county.[9]
- Opioid-related hospitalizations have increased over 75% from 0.9 per 1,000 (2005) to 1.6 per 1,000 (2014).[10]
- The rate of opioid-related deaths increased over 60% between 2009 and 2016 to 18 per 100,000 (below). This reflects an increase of over 100% from 2008-2016, doubling the number of opioid deaths from 396 to 827.[11]
- The Wisconsin opioid death rate was highest among black people in 2012-2016.[12]

Wisconsin's opioid death rate[13]



Key Findings

- Wisconsin rates and dosage of opioid prescriptions have decreased from 2014 to 2016.
- Wisconsin opioid related hospitalizations and the number of opioid-related deaths are increasing.
- More Wisconsin children are removed from their home due to adult drug use, and more infants are being born with Neonatal Abstinence Syndrome and other drug-related health issues.
- Use of methamphetamines has increased in Wisconsin.

Drug Use Among Children and Youth in the United States

- Opioids are the leading cause of teenage drug deaths.[14]
- Drug overdoses from all drugs among adolescents 15-19 decreased from 2007-2014, but increased in 2015.[15]
- Prescriptions for opioids decreased in 2014-2016 from 2.6 prescriptions per 100 people to 2/100 for youth under 14, as well as for 15-19 year olds, from 12.8 to 11.6/100.[16]
- Meth use decreased from 9% to 3% of youth from 1999 to 2015. Wisconsin data indicates that the state follows this national trend, with youth meth use dropping by 50%. In Milwaukee, however, meth use doubled to 6.6% from 2005-2013.[17]

Opioid and Methamphetamine Use (page 2)

Impact on Drug Misuse on Children and Families

- In 2016, 9% of U.S. children lived with someone with an alcohol or drug problem. Those children typically had co-occurring ACEs (91%).[18]
- Children of caregivers who use and/or make meth are at risk for physical and sexual abuse, neglect, fires and explosions, medical problems, and exposure to hazardous lifestyles.[19]
- Children of mothers who had a substance use disorders have higher levels of externalizing problems, depression, and school difficulties.[20]
- Babies born dependent on addictive drugs may lower the parent's confidence and satisfaction resulting in challenges with bonding and attachment.[21]

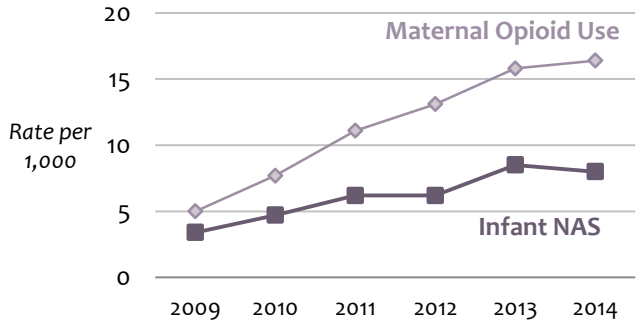
Impact of Opioids on Infants

- Between 2009 and 2014, Wisconsin maternal opioid use has tripled resulting in an increase in babies born with Neonatal Abstinence Syndrome (NAS).[25]
- Babies born to mothers using opioids have a 50% risk of being born with NAS, and an increased likelihood of other negative outcomes, including premature birth, poor fetal growth, or death.[26]
- Opioid treatment programs increase positive outcomes for pregnant women and their children.[27]

Wisconsin Out-of-Home Care

- The number of children removed from their homes increased steadily from 2012 to 2017, reaching a ten year high in October 2017 with 7,826 children in placements on October 1. The growth in out-of-home care placements has been almost entirely in non-Milwaukee counties.[22]
- Over the past seven years, the number of children removed from their home and placed in an out-of-home care setting due to parent/caregiver drug abuse has more than doubled from 479 in 2009 to 1,252 in 2016. It is likely that this data under-represents the actual number.[23,24]

Wisconsin's rate of maternal opioid use and reports of infant NAS attributed to opioid use, per 1,000 live births[28]



References

1. Plotzker, Rosalyn E., David S. Metzger, and William C. Holmes. "Childhood sexual and physical abuse histories, PTSD, depression, and HIV risk outcomes in women injection drug users: a potential mediating pathway." *The American Journal on Addictions* 16.6 (2007): 431-438.
2. Quinn, Kelly, et al. "The relationships of childhood trauma and adulthood prescription pain reliever misuse and injection drug use." *Drug and alcohol dependence* 169 (2016): 190-198.
3. De La Cruz, Donna. Opioids May Interfere with Parenting Instincts, Study Finds. New York Times Online, published 10/13/2016. Retrieved from https://www.nytimes.com/2016/10/13/well/family/opioids-may-interfere-with-parenting-instincts-study-finds.html.
4. Sommers, I., Baskin, D., & Baskin-Sommers, A. (2006). Methamphetamine use among young adults: health and social consequences. *Addictive behaviors*, *31*(8), 1469-1476.
5. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016. Tables 1.2A and 1.6A. Retrieved 10/30/2017 from *https://www.samhsa.gov*
6. WSIC. (2017).2016 Wisconsin Methamphetamine Study. Presentation slides retrieved 11/13/2017 from https://www.doj.state.wi.us/sites/default/files/news-media/2.9.17_Meth_Hearing_FBI.pdf.
7. Centers for Disease Control and Prevention. (2017) Annual Surveillance Report of Drug-Related Risks and Outcomes | United States. Atlanta, GA. Retrieved from https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf.
8. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016. Table 1.27B. Retrieved 10/30/2017 from *https://www.samhsa.gov*
9. Centers for Disease Control and Prevention. (2017) U.S. County Prescribing Rates, 2016. Atlanta, GA. Retrieved 10/10/2017 from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
10. WI Department of Health Services, Division of Care and Treatment Services and Division of Public Health. Wisconsin Epidemiological Profile on Alcohol and Other Drugs, 2016. November 2016. Retrieved 10/6/2017 from https://www.dhs.wisconsin.gov/stats/aoda.htm
11. Wisconsin Department of Health Services. (2015). WISH, *Wisconsin Opioid Death Module* [Data file]. Retrieved 10/25/2017 from https://wish.wisconsin.gov.
12. IBID
13. IBID
14. Curtin, Sally C. Drug Overdose Deaths Among Adolescents Aged 15-19 in the United States. NCHS Data Brief No 282, August 2017.
15. IBID
16. IBID
17. Centers for Disease Control and Prevention (2017) High School YRBS Online Query Tool. Analyzed by OCMH on 10/12/2017 from https://nccd.cdc.gov/youthonline.
18. Bethell, CD, et al. Issue Brief: Adverse Childhood Experiences Among US Children, Child and Adolescent Health Measurement Initiative, Johns Hopkins Bloomberg School of Public Health, October 2017: cahmi.org/projects/adverse-childhood-experiences-aces
19. The White House, Office of National Drug Control Policy. National Drug Control Strategy. Washington DC. February 2006.
20. Slesnick, N., Feng, X., Brakenhoff, B., & Brigham, G. S. (2014). Parenting under the influence: The effects of opioids, alcohol and cocaine on mother–child interaction. *Addictive behaviors*, *39*(5), 897-900.
21. IBID
22. Bove, Fredi-Ellen. (2017). *Drug Abuse and the Child Welfare System.* Madison, WI.
23. IBID
24. Department of Children and Families. Child and Youth Needs – Parental Needs Dashboard. Accessed 10/29/2017. https://dcf.wisconsin.gov/reports?accactive=1
25. Department of Health Services. (2015). *Neonatal Abstinence Syndrome (NAS) in Wisconsin, Publication 01-124.* Division of Care and Treatment Services. Madison, WI. Retrieved 10/10/2017 from https://www.dhs.wisconsin.gov/publications/p01124.pdf.
26. Whiteman, V. E., Salemi, J. L., Mogos, M. F., Cain, M. A., Aliyu, M. H., & Salihu, H. M. (2014). Maternal opioid drug use during pregnancy and its impact on perinatal morbidity, mortality, and the costs of medical care in the United States. *Journal of pregnancy*, *2014*.
27. Center for Substance Abuse Treatment. (2005). Medication-assisted treatment for opioid addiction in opioid treatment programs.
28. Department of Health Services. (2015). *Neonatal Abstinence Syndrome (NAS) in Wisconsin, Publication 01-124.*

Wisconsin Office of Children's Mental Health

FACT SHEET: Outpatient Mental Health Service Data for Children on Medicaid

Medicaid. In Wisconsin, the Medicaid program is more commonly known as BadgerCare or Title 19. BadgerCare Plus refers to the part of Wisconsin's Medicaid program which insures children, children in foster care, children receiving Social Security Income (SSI)[1], and low-income or disabled adults. Within the OCMH fact sheets, we use the term Medicaid.

Children Served in Outpatient Settings[1]

The number of children using Medicaid outpatient mental health services has increased since 2012. Medicaid outpatient services reached 7.3% of Wisconsin's Medicaid population under 18 (44,123, 7% increase from 2013) and 7.9% of children on Medicaid in 2015 (47,776, 8% increase from 2014). Individual children are also receiving more outpatient sessions. In 2012, 50% of children received more than four outpatient visits, and in 2015, this increased to 60% of children receiving four or more visits.

Key Findings

- Medicaid is the largest payer of children's mental health services in Wisconsin.
- Children's mental health outpatient services have increased in number of children served, number of sessions provided, and total amount spent since 2012.
- Children in Wisconsin's north and northwest receive, on average, more therapy visits.

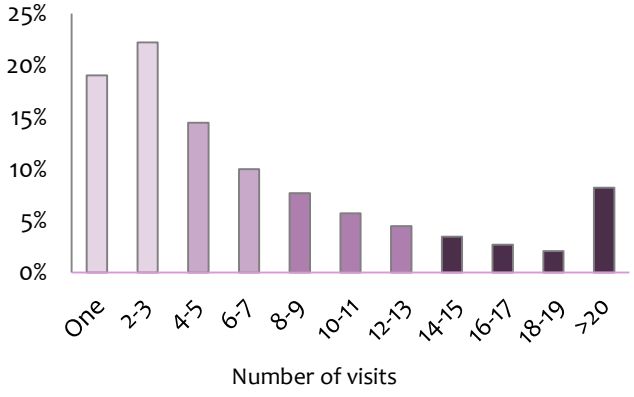
Dollars Spent on Outpatient Mental Health[2]

The cost to Medicaid for children's outpatient mental health services has been increasing since 2012. In 2014, Wisconsin spent $18.9M ($1.45 per child under 18 in Wisconsin); this increased 20% to $22.8M ($1.76) in 2015.

Number of Outpatient Sessions

In 2015, the number of sessions varied from two to nine across the state. On average, almost 20% of youth received only one outpatient session, though 50% received five or more.

Percent of children by number of outpatient mental health sessions in one year (2015)

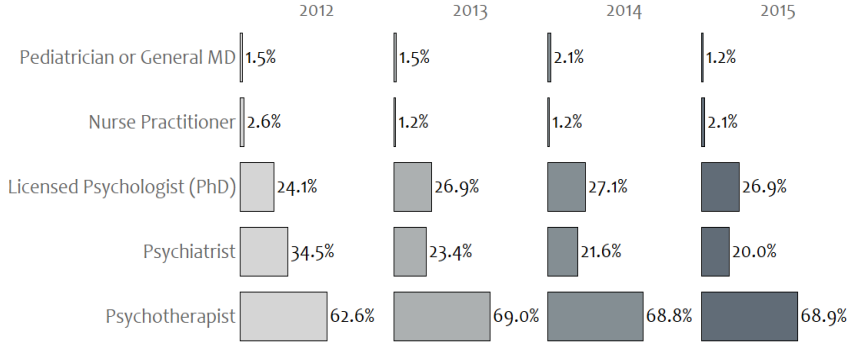


On average, girls received more sessions than boys. Hispanic, black, and other minority youth had approximately 20% fewer visits than white children in 2015.

Provider Type[3]

In 2015, most Wisconsin children receiving Medicaid mental health services saw a therapist (e.g., licensed clinical social worker, professional counselor, marriage and family therapist). Approximately 20% of children saw a psychiatrist which is down from 35% of children in 2012.

Percent of children receiving outpatient therapy from different provider types, by year



The number of psychologists who provided outpatient mental health services to Medicaid covered children in Wisconsin increased from 446 in 2012 to 514 in 2015, as did the number of psychotherapists (1,603 to 1,988). The number of psychiatrists has decreased slightly (325 to 308 in 2015).

The estimated number of psychiatrists practicing in the state (Medicaid and non-Medicaid) has fluctuated over the last 10 years with around 7 per 100,000 WI residents. The number of psychologists has also fluctuated, with an average of 40 per 10,000 residents.[4]

Outpatient Mental Health Service Data for Children on Medicaid
(page 2)

Service Differences by County[5]

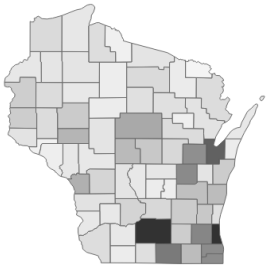
Lightest purple represents four or fewer child sessions, while darkest purple represents seven or more sessions.

Counties in the north and north west provide more sessions per child on average.

Despite having fewer providers in the northern region, children receive comparable or higher numbers of sessions, likely due to the smaller number of total children served.

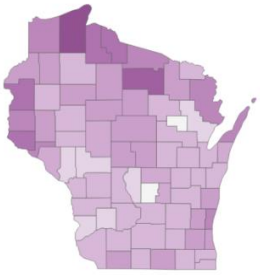
Average number of Medicaid children who received any outpatient mental health sessions per county (2015)

< 25 children — > 3,000 children



Average number of outpatient mental health sessions per child (2015)

2 per child — 9 per child



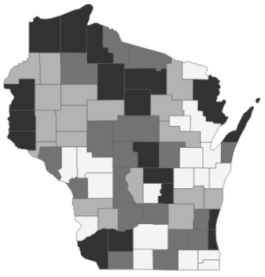
Percent of children who received any outpatient mental health sessions under Medicaid per county (2015)

1% — 10%

Spending Differences by County

Counties that spend more per child on psychiatric hospitalizations, typically spend more per child on outpatient services. However, some counties are in the higher quartiles for outpatient spending but lower quartiles for inpatient spending.

Quartiles of child Medicaid mental health spending (all services) (2015)

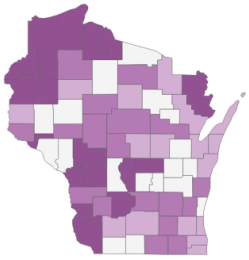


Highest Spending

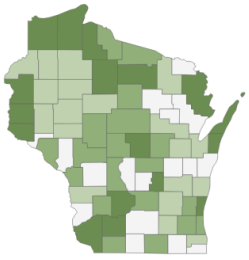
Lowest Spending

Quartiles of child Medicaid mental health spending (only hospitalization or outpatient therapy) (2015)

Hospitalization Quartiles ($)



Outpatient Quartiles ($)



Parent and Youth Voice[6]

Outpatient mental health therapy is typically provided in a clinic and transportation can be a barrier. Alternative locations such as treatment in a child's home or school may support a family's ability to receive services and supports.

Prior Authorization regulations impeded families' ability to receive timely services, but these regulations recently changed eliminating what many described as a service barrier.

Outpatient mental health therapy is often the first and only treatment option, but it may not be the most effective service for all children, compared to alternative therapies such as equine assisted therapy, or more intensive services such as day treatment.

References

1. Wisconsin Department of Health Services. (2012-2015). Medicaid claims spending [Data file]. Received 3/1/2017 from the Division of Medicaid Services. "Outpatient mental health services" are classified as having a mental health procedure code and a mental health diagnosis in the first or second diagnosis line on the claim.
2. Wisconsin Department of Health Services. (2015). WISH, Wisconsin Population Module [Data file]. Retrieved 10/18/2017 from https://wish.wisconsin.gov.
3. Wisconsin Department of Health Services. (2012-2015). Medicaid claims spending [Data file]. Received 3/1/2017 from the Division of Medicaid Services. "Outpatient mental health services" are classified as having a mental health procedure code and a mental health diagnosis in the first or second diagnosis line on the claim.
4. United Stated Department of Labor, Occupational Employment Statistics. (2010-2016). *State Occupational Employment and Wage Estimates* [Data file]. Retrieved 10/18/2017 from https://www.bls.gov/oes/2016/may/oes_wi.htm#21-0000.
5. Wisconsin Department of Health Services. (2015). WISH, Wisconsin Population Module [Data file]. Retrieved 10/18/2017 from https://wish.wisconsin.gov.
6. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov/Pages/Integrate/ParentandYouthPartners.aspx

Wisconsin Office of Children's Mental Health

FACT SHEET: Psychotropic Medication Prescribing for Children on Medicaid

Psychotropic Medication and Prescribing Patterns

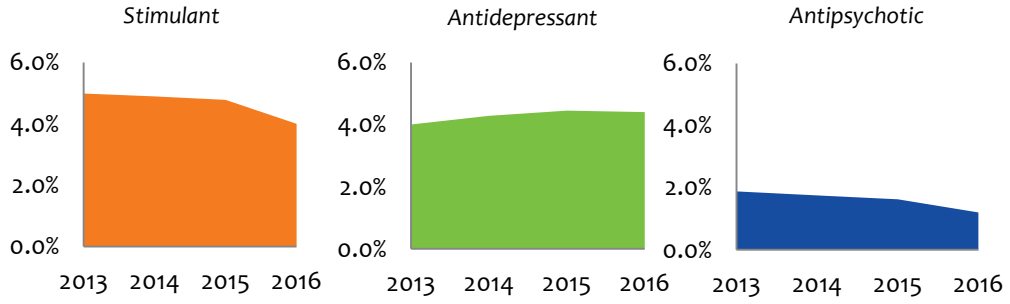
Psychotropic medications (e.g., stimulants, antidepressants, and antipsychotics) are used to treat mental health issues. In 2016, 7.8% of Wisconsin youth on Medicaid received psychotropics compared to 9.9% of youth on Medicaid nationally.[1,2]

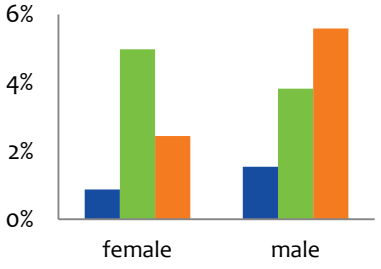
Wisconsin saw an almost 40% reduction from 2013 to 2016 of antipsychotic youth prescriptions following the 2012 dissemination of a Wisconsin Department of Health Services informational memo to Medicaid prescribers regarding youth antipsychotic prescribing guidelines.[2] Following the 2013 dissemination of an informational memo regarding youth stimulant prescribing guidelines, there was a 50% reduction in the number of children who received prescriptions that exceeded the maximum daily dose threshold.[3]

When youth are prescribed psychotropics, the recommended course of treatment is concurrent psychotherapy. However, in 2016, only 36% of Wisconsin youth on Medicaid with psychotropic prescriptions received psychotherapy;[2] this percentage has remained steady from 2013-16. Older youth (ages 12-18) are more likely to concurrently receive therapy and medication, compared to children under 12 (40% vs 32%).[2]

Wisconsin Youth and Drug Class[2]

The tables to the right note the percent of youth prescribed three different types of psychotropics: stimulants, antidepressants, and antipsychotics. Prescriptions of antidepressants outnumbered stimulants and continues to increase as of 2016.



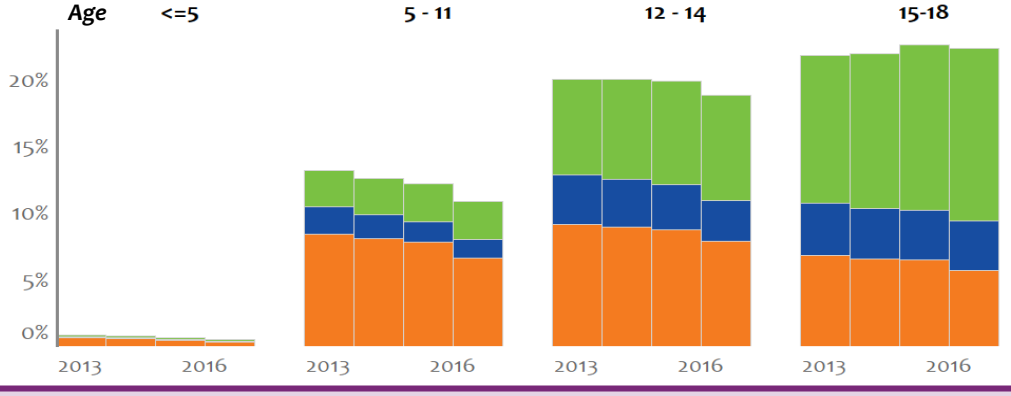


Gender

- Wisconsin males under 21 are more likely to receive any psychotropics (8.8% versus 6.9% of females).
- Wisconsin females are almost twice as likely as males to be prescribed **antidepressants** (51.4% vs 31.6% of males)
- Wisconsin males are more likely to be prescribed **stimulants** (47.8% vs 26.5% of females).

Age

- Prescriptions of psychotropics in children under 14 is decreasing due to decreasing prescription rates of **stimulants.**
- Youth between 15 and 18 are receiving more pyschotropics due to increasing prescription rates of **antidepressants.**

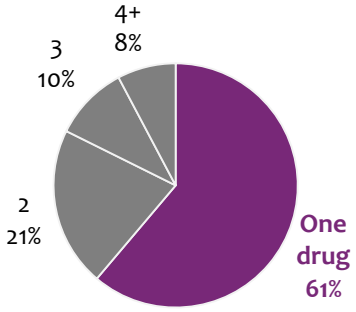


Key Findings

- Prescriptions of antipsychotics and stimulants for children on Medicaid decreased from 2013 to 2016.
- Psychotropic prescriptions for children under age 11 decreased about 30%.
- Children under the age of 12 are less likely to receive concurrent psychotherapy and medications than youth from 12-18 years of age (32% vs 40% older youth).
- 39% of Wisconsin youth on Medicaid receive more than one psychotropic medication.

Psychotropic Medication Prescribing for Children on Medicaid
(page 2)

Polypharmacy is defined as filling a prescription that overlaps three months with another prescription. Most children on Medicaid in Wisconsin receive **only one psychotropic medication**. In 2016, of the 39% of youth who received more than one medication, half received two psychotropics.[2]



Attention Deficit Hyperactivity Disorder (ADHD)

Wisconsin children are prescribed medication to treat ADHD more than the national average (81% vs 74% national).[4]

Prescribers are advised to evaluate youth with ADHD symptoms for other issues such as co-existing mental health issues, trauma history, and overwhelming stress. According to one small study, Wisconsin prescribers inconsistently used ADHD symptom checklists.[3]

Because trauma symptoms are often indistinguishable from ADHD symptoms, encouraging prescribers use of a trauma symptom screen would assist in formulating the best course of treatment.

Parent and Youth Voice[5]

With a thorough knowledge of a child's history, medication can help support the child at home and school, particularly along with therapy.

Having the entire care team on the same page is critical for the success of a child and family, and can be particularly important when planning and prescribing medication. One youth was on fourteen different drugs from seven different prescribers at one time. Lack of coordinated care, along with the interaction from multiple public systems such as foster care and juvenile justice, can lead to provider and consumer confusion around medications.

It can seem to parents like schools and providers see medication as the first-line or only method to reduce behavioral issues. This can influence families to seek psychotropic medications when other treatments and supports might be less restrictive and more effective in the long-term.

References

1. Howie, LaJeana. (2014) *Use of medication prescribed for emotional or behavioral difficulties among children aged 6-17 years in the United States, 2011-2012*. NCHS Data Brief. No. 148.
2. Wisconsin Department of Health Services. (2013-2016). *Medicaid psychotropic prescribing patterns* [Data file]. Received 8/1/2017 from the Office of Health Informatics.
3. Wisconsin Drug Utilization Project. (2015). *Stimulant Drug Use in Children and Adolescents*. Madison, WI. Retrieved from www.forwardhealth.wi.gov.
4. National Center on Birth Defects and Developmental Disabilities. (2003-2011). *State Profile: ADHD Treatment in Wisconsin. Division of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention* Retrieved 5/15/2017 from www.cdc.gov/adhd.
5. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

FACT SHEET: Resilience

Resilience

Challenging and even highly stressful events can promote resilience when a child is surrounded by supportive relationships and a safe environment.[1] Research from the 2017 Health Outcome of Positive Experiences (HOPE) study emphasizes the importance of positive experiences in day-to-day relationships, which has been shown to have lasting impacts on physical and mental health.[2] Additional research indicates that positive and supportive relationships provide the buffering that allow children and youth to withstand and recover from adverse experiences.[3] In Wisconsin, 72% of high school students feel that they have someone at school they can talk to.[4]

Adverse Childhood Experiences (ACEs)

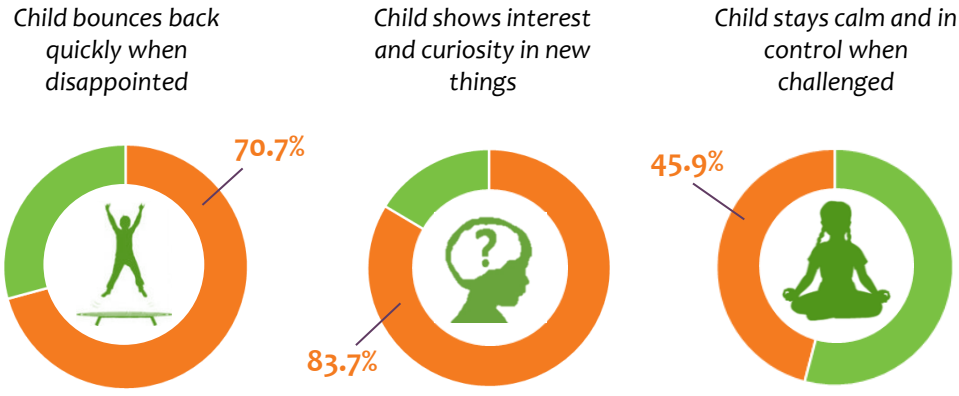
An ACE is a negative childhood event that can include experiences such as neglect or abuse, living with a parent who has substance use issues, or being exposed to domestic violence. These experiences are correlated with many negative social outcomes and physical health issues. In 2015, 56% of Wisconsin adults had one or more ACEs, and 14% had four or more.[5]

Promoting Family Resilience through Problem Solving

- Talking about the problem as a family
- Working together to solve the problem
- Knowing and identifying family strengths
- Remaining hopeful when facing a problem

In Wisconsin, 78% of children live in families engaged in all four of the above activiites.[6] Wisconsin families are particularly good at recognizing their strengths and staying hopeful when facing problems.

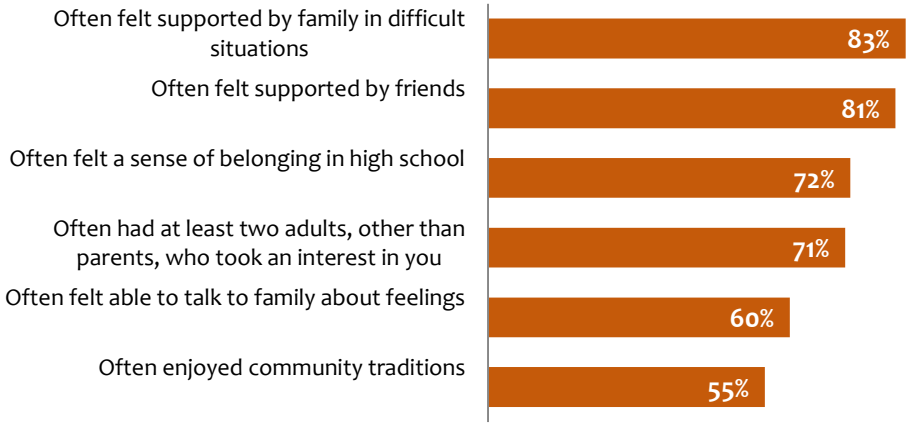
Measures of childhood resilience[7]



Resilience in Wisconsin's Adults

Social support is defined as "having friends and other people, including family, to turn to in times of need or crisis to give you a broader focus and positive self-image." Social support improves quality of life and acts as a buffer against adverse life experiences.[8]

Percent of Wisconsin adults reporting the following social supports[9]



Resilience Factors

Two powerful protective factors include:[10]

- Feeling that family stands by you in hard times
- Having someone to talk with about difficult feelings

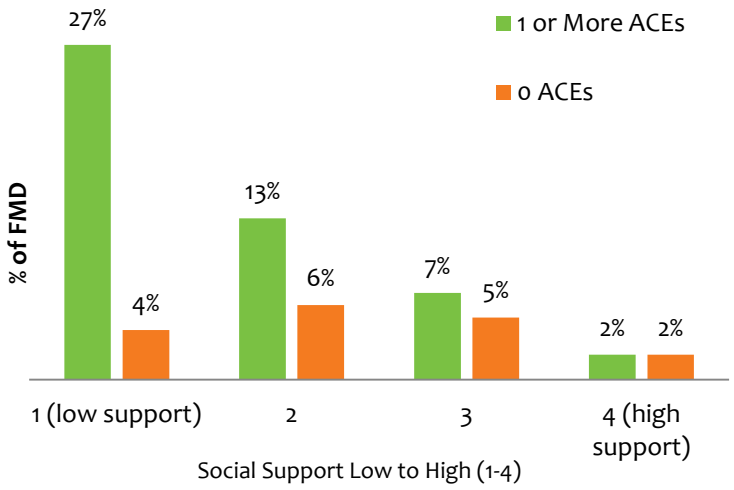
Most Wisconsin adults feel supported by family (83%) and by friends (81%).[11]

Resilience (page 2)

Social Support Protects against Mental Distress

Frequent Mental Distress refers to the experience of stress, depression, or emotional problems for 14 or more days within the previous 30 days. In 2015, 10% of Wisconsin residents experienced frequent mental distress. Data from the Wisconsin Behavioral Risk Factor shows the correlation between social support and ACEs on the impact of frequent mental distress, demonstrating how individuals with higher ACEs have lower frequent mental distress in the presence of more social support. This suggests that access to strong social support enables individuals, regardless of an ACEs score, to experience less frequent mental distress, and have better outcomes overall.[12,13]

Percent of Wisconsin individuals with frequent mental distress by social support for those with and without ACEs[14]



Agencies serving youth can do the following to promote resilience:

- Develop caring interpersonal interactions based on respect, empathy, strengths, attentive listening and positive feedback.
- Engage in meaningful participation by recognizing young people's values and contributions.
- Promote high expectations with accompanying support.
- Empower young people to identify and master skills of interest.
- Listen.
- Promote creative expression.
- Capitalize on individuals altruism and willingness to support and serve others.
- Support individuals in embracing cultural identity.

Parent and Youth Voice[15]

Focusing on a child and parent's strength goes a long way to build trust and deepen relationships.

Reframing challenges as opportunities builds confidence and motivation.

Listening without judgement helps rejuvenate a youth or parent who has been struggling.

References

1. Sege, R., Bethell, C., Linkenbach, J., Jones, J., Klika, B. & Pecorac, P.J. (2017). *Balancing adverse childhood experiences with HOPE: New insights into the role of positive experience on child and family development*. Boston: The Medical Foundation. Accessed on 9/20/17 at www.cssp.org.
2. IBID
3. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. (2016). *National survey of children's health* [Data query]. Retrieved 11/3/17 from http://childhealthdata.org/browse/survey?q=4616&r=51.
4. Centers for Disease Control and Prevention. (2017). *Wisconsin 2017 Youth Risk Behavior Survey Summary Tables*. Retrieved 11/7/2017 from https://dpi.wi.gov/sspw/yrbs.
5. Wisconsin Department of Health Services. (2015). *Wisconsin behavioral risk factor survey* [Data file]. Retrieved from http://dhs.wisconsin.gov/stats/BRFS.htm.
6. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. (2016).
7. IBID
8. Office of Children's Mental Health Resiliency Workgroup. For more information please visit https://children.wi.gov/Pages/Integrate/Resilience.aspx
9. Wisconsin Department of Health Services. (2015).
10. Sege, R. (2017).
11. Wisconsin Department of Health Services. (2015).
12. IBID
13. University of Minnesota. (2016). *Taking charge of your health and wellbeing: Social support*. Retrieved on 10/9/17 from https://www.takingcharge.csh.umn.edu/social-support
14. Wisconsin Department of Health Services. (2015).
15. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

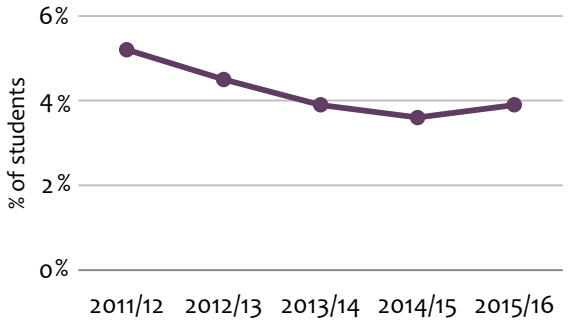
FACT SHEET: School Outcomes

Suspension and Expulsion

Nationally, almost 3 million students are suspended or expelled each year. These students are more likely to be held back, drop out of school, or be involved in the juvenile justice system.[1] School discipline policies are linked to a child's mental well being, both as a cause (children with behavioral disabilities are more likely to be disciplined), and as an effect (children who are suspended or expelled are at greater risk for negative outcomes).[2]

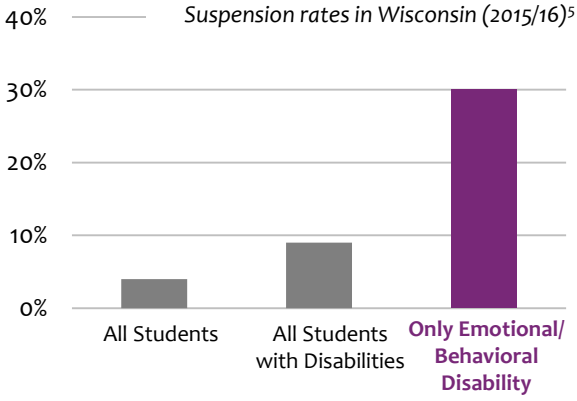
Overall Wisconsin expulsion and suspension rates have decreased. Expulsions for all students decreased by 50% in 2014/15 but increased slightly for all students in 2015/16.[3]

Suspension rates in Wisconsin by year



High suspension rates remain for students with disabilities.[4] Students with Emotional/ Behavioral Disabilities (EBD) experienced a slight reduction in overall suspensions and expulsions but are still expelled almost eight times as frequently as the general student body.

Suspension rates in Wisconsin (2015/16)[5]



Suspension rates are higher for Wisconsin black students.[6]

- Black students are suspended 7.5 times more than white students.
- Rates of suspension for black students decreased 30% in the last three school years, but rose in 2015/16.

Percent of students suspended by race and ethnicity (2015/16)

2.0% of White students

4.4% of Hispanic students

17.6% of Black students

Key Findings

- Suspension and expulsion put children at risk for negative outcomes including lower graduation rates and future involvement in the youth justice system.
- Nationally preschool children are expelled at a rate higher than school children in grades K through 12. In Wisconsin, around 1% of kindergarteners are suspended, though rates are higher at charter schools.
- Wisconsin has some of the highest graduation rates for White children and some of the lowest rates for Black children.
- Wisconsin four year graduation rates have remained stable for students with disabilities and most racial groups.

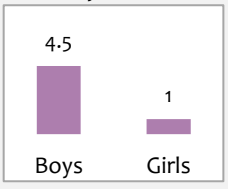
Early Childhood Discipline

Preschool expulsions outnumber Kindergarten through 12th grade expulsions.[7] Nationally, 10% of preschool teachers have expelled at least one child during the past year.[8]

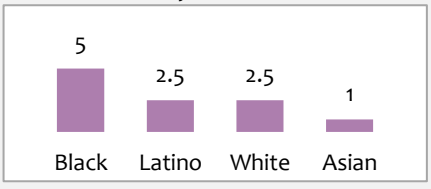
Some early childhood programs prohibit suspensions and expulsions and instead provide staff with skills to manage challenging child behaviors.[9] Yet 2 of every 1,000 pre-school children and 11 out of 1,000 kindergarteners in Wisconsin students were suspended in 2015/16.[10]

Suspension rates differ among sub groups. For example, young boys are 4.5 times more likely to be suspended than girls, and black children are 5 times more likely to be suspended than children of other races.[11] (see bar graphs below)

By Gender

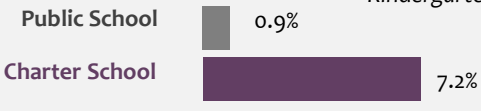


By Race



Charter schools suspend more kindergarteners than public schools.

Kindergarten suspension rate (2015/16)[12]

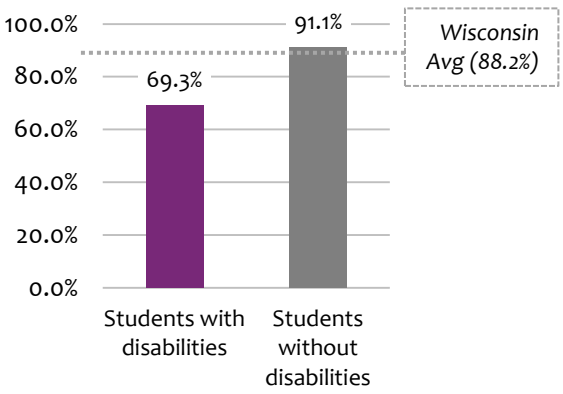


School Outcomes (page 2)

High School Graduation Rates[13]

Compared to the U.S., more Wisconsin youth graduate from high school on time (82.3% vs. 88.2%).

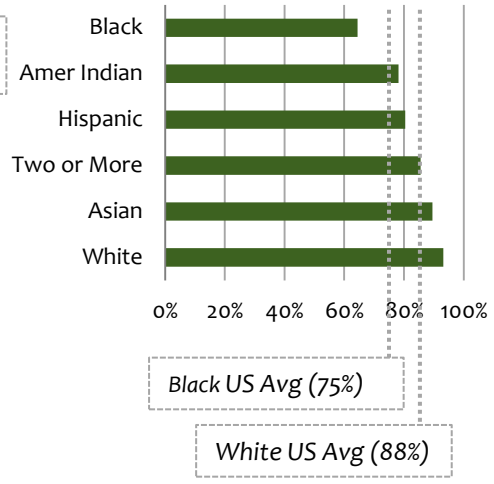
Four-year graduation rates in Wisconsin by disability status (2015/16)[14]



Graduation Rates by Race and Ethnicity

Wisconsin has some of the highest graduation rates for White children and some of the lowest rates for Black children.

Graduation rates by race and ethnicity in Wisconsin (2015/16)[15,16]



Trends in Graduation Rates

Wisconsin four year graduation rates have remained stable for students with disabilities and most racial groups. American Indians and Hispanic students have seen a slight increase from 2012/13 to the 2015/16 school year.[17]

Other School Facts

Type of School

- In the Midwest, 11.2% of students go to private school, compared to 9.8% nationally.[18]
- Just over 4% of Wisconsin students attended a charter school in 2015/16. Nationally, 3.1 million students attend charter schools, accounting for 6% percent of all students.[19,20]

Academic Achievement

- Less than half of Wisconsin students perform at Advanced or Proficient levels of standardized testing in Math, Science and Social Studies.[21]
- In the US, 69.2% of graduates continue to college, compared to 61.3% in Wisconsin.[22,23]

Non-Enrolled Students

- 14,000 teens in Wisconsin aged 16 to 19 are not enrolled in school and are not working.[24]

Parent and Youth Voice[25]

Parents can be partners in providing schools with strategies to prevent challenging behaviors – often this is as simple as having one trusted adult at school who the child can talk to when feeling stressed. Youth appreciate co-creating de-escalation strategies that allow them to stay in school while still keeping other students and teachers safe.

References

1. US Department of Education. (2016). *A First Look*. Washington DC. Retrieved from Child Trends Newsletter, September 28, 2017.
2. Anyon, Y., Gregory, A., Stone, S., Farrar, J., Jenson, J. M., McQueen, J., & Simmons, J. (2016). Restorative interventions and school discipline sanctions in a large urban school district. *American Educational Research Journal*, *53*(6), 1663-1697.
3. WI Department of Public Instruction. (2012-2016). *WISEdash Discipline Data* [Data file]. Retrieved from http://wisedash.dpi.wi.gov/
4. IBID
5. Data request from WI Department of Public Instruction. *Requested Data for EBD Student Comparisons, 2015/16* [Data file]. Data received 10/4/2017.
6. WI DPI. (2012-2016). *WISEdash Discipline Data* [Data file].
7. Sciamanna, John. (2017). *Preschool Children Have Higher Expulsion Rates than K-12*. Retrieved from http://www.cwla.org/preschool-children-have-a-higher-expulsion-rates-than-k-12/
8. Hammond, Jessica. (2017). *Information and Resources to Assist States in Developing Policy on Early Childhood Suspension and Expulsions.* Center on Enhancing Early Learning Outcomes. Retrieved 9/22/2017 from zerotothree.org.
9. Hammond. (2017).
10. WI DPI. (2012-2016). *WISEdash Discipline Data* [Data file].
11. IBID
12. IBID
13. NCES. (2017). *Public High School Graduation Rates*. Retrieved from https://nces.ed.gov/programs/coe/indicator_coi.asp on 9/28/2017.
14. WI Department of Public Instruction. (2015/2016). *WISEdash Graduation Rates* [Data file]. Retrieved from http://wisedash.dpi.wi.gov/
15. IBID
16. NCES. (2017).
17. WI DPI. (2015/2016). *WISEdash Graduation Rates* [Data file].
18. National Alliance for Public Charter Schools. (2016). *Estimated Charter Public School Enrollment, 2016-17.* Retrieved 10/9/2017 from www.publiccharters.org.
19. IBID
20. National Center for Education Statistics. (2017). *Fast Facts: Back to School Statistics*. Retrieved 10/9/2017 from https://nces.ed.gov/fastfacts/display.asp?id=372.
21. WI Department of Public Instruction. (2016/2017). *WISEdash Forward (State Standards)* [Data file]. Retrieved from http://wisedash.dpi.wi.gov/
22. NCES. (2017).
23. National Center for Higher Education Management System. (2014). *College-Going Rates of High School Graduates.* Retrieved 10/9/2017 from http://www.higheredinfo.org/.
24. CWLA. (2017). *Wisconsin's Children 2017.* Retrieved from www.cwla.org on 9/25/2017.
25. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

FACT SHEET: Services for Children with Delays or Disabilities

The **Wisconsin Department of Health Services (DHS)** has a number of programs that serve children with emotional, behavioral, developmental and physical disabilities or delays through Medicaid or IDEA funding.

The Birth to 3 Program serves children under the age of three who have delays or disabilities and their families through therapies mainly provided in the home.

The Children's Long-Term Support (CLTS) Waiver Program is a Home and Community-Based Service Waiver that provides Medicaid funding for children who have significant developmental, physical, or emotional disabilities leading to substantial limitations in their daily activities.

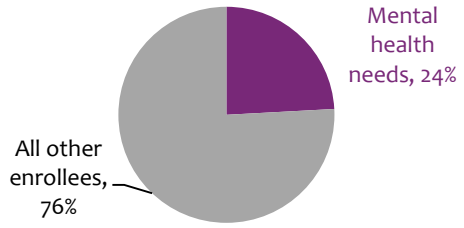
Other funding streams for supports and services for children with disabilities include the Children's Community Options Program (CCOP), and the Katie Beckett Program.

Number of Children Served

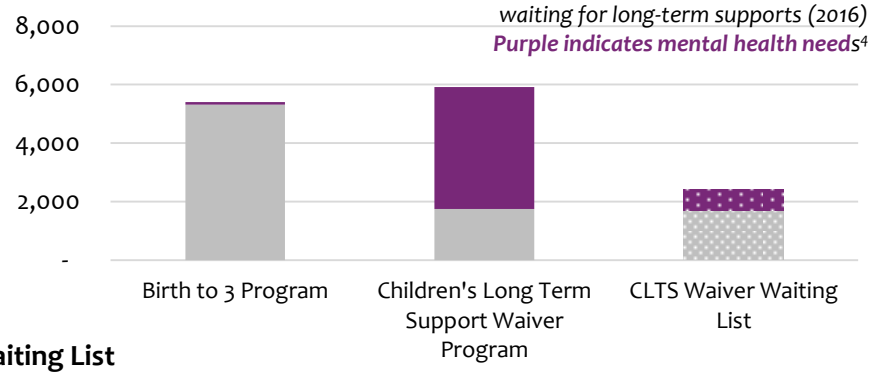
In 2016, the Wisconsin long-term support programs served 24,247 children with disabilities, 5,854 of whom had a mental health diagnosis.

Children with mental health needs make up 1.4% of the Birth to 3 Program population, 70% of the CLTS population, and 30% of the current waiting list.[3]

1 in 4 Wisconsin children with a disability receiving long-term supports had mental health needs (2016)[3]



Number of Wisconsin children served or waiting for long-term supports (2016)
Purple indicates mental health needs[4]



Children's Long-Term Support Waiver Program Waiting List

The CLTS Waiver Program waiting list held just over 2,600 children at the end of 2016, and about **30% of those children (751) have social, emotional, or mental health needs.** Some children receive supports while on the waiting list, though most (75%) do not. To support children with disabilities, an additional $39.2 million will be put towards eliminating this waiting list in the 2017/19 budget.[1]

Why is eliminating the CLTS waiver program waiting list important?

Families with children with disabilities are more likely to live in poverty, making it more difficult to provide the extra supports and services that their child needs. Nationally 48% of children with disabilities and 53% of children with mental health disabilities specifically, live in families under 200% of the federal poverty level, compared to only 42% of children without disabilities.[2]

Key Findings

- One in four Wisconsin children with a disability receiving long-term supports in 2016 had mental health needs.
- Fewer younger children (under three) with social emotional needs are served compared to older children with a disability served.
- Additional funding to the Children's Long-Term Support Waiver Program will support an additional three thousand children, about 30% of whom have a mental health diagnosis.
- The CLTS Waiver Program provides many services for children and families; respite care funded at $8.7 million/year, is highly valued by parents.

Definitions: The Wisconsin Department of Health Services, Division of Medicaid defines a child with "mental health needs" as a child who has a mental health diagnosis listed on his/her most recent Children's Long Term Support Functional Screen. Other reports may use the term "Serious Emotional Disturbance" (SED) an eligibility category, to count the number of children in CLTS Waiver Program, CCOP, or the Birth to 3 Program. This report instead includes all children with mental health needs, though they may be eligible for long-term supports through a primary physical or developmental disability. Many children in these programs have dual diagnoses of physical, developmental, and/or social/emotional disabilities.

Services for Children with Delays or Disabilities (Page 2)

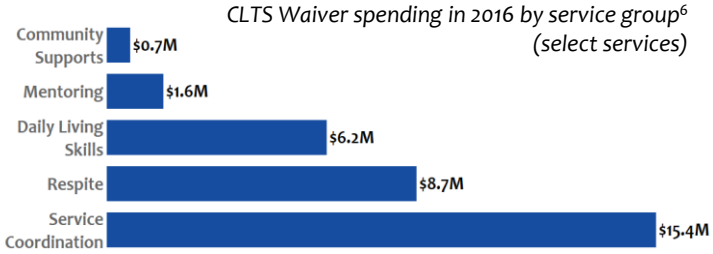
CLTS Waiver Program Spending

The CLTS Waiver Program provides Medicaid funding for a range of services based on the needs of the child and family.

In 2016, CLTS spent 8.7 million on respite for all children (not just those with mental health needs) , 12% of the total spending in that year.

Other services that support social and emotional skills and a child's integration into the community include community supports, mentoring, and daily living skills.[6] This program also provides funding for additional services (not shown), including service coordination, the most frequently used support.

CLTS Waiver spending in 2016 by service group[6] (select services)



Infants Under 3 Years Old with Delays or Disabilities[5]

In 2014, the Wisconsin Birth to 3 Program served around 5,760 children with delays or disabilities, which is 2.8% of the children under age three in Wisconsin. These programs primarily serve speech/language, developmental disabilities, and autism. Few children are identified as having emotional or behavioral disabilities (just under 1% of children served).

A guiding principle of the Birth to 3 Program is to support families who are viewed as the child's greatest resource. As such, the program tracks outcomes relating to family services and supports (below).

Percent of families reporting that the Birth to 3 Program helped in specific ways (program year 2015)[5]

Family and Youth Experience[8]

Flexible funding available through CLTS provides families with supports to keep their children out of hospitals and institutions. Of particular importance is respite care, which allows families a break from caretaking and puts a trained caregiver in the home or other location of the family's choice.

Some families worry about losing long-term care eligibility. These programs have strict functional eligibility requirements and children may lose eligibility if their needs decrease.

Infants, Toddlers, and Children 3 to 5 Years Old with Delays or Disabilities[7]

Wisconsin's Department of Public Instruction has an early childhood special education program (IDEA Part B, 619) program that served 7.6% of children ages 3-5 in 2014. In this same year, 50.8% of infants and toddlers, and 79.1% of 3-5 year olds, substantially improved their social-emotional skills.

References

1. Walker, S. (2017). *Protecting Wisconsin's most vulnerable: Governor Walker's budget proposal eliminates children's long-term supports waiting list.* Retrieved 4/20/2017 from https://walker.wi.gov/. (In Press).
2. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. (2016). *National Survey of Children's Health* [Data query]. Retrieved 10/31/2017 from www.childhealthdata.org.
3. Wisconsin Department of Health Services. (2016). Number of Children Enrolled in Bureau of Children's Services Programs [Data file]. Received 7/25/2017 from Division of Medicaid. Data represents the number of children served at any point in 2016.
4. IBID. Data represents census as of October 1, 2016.
5. Wisconsin Department of Health Services. (2016). Part C and Part B 619 Data Display: Wisconsin, covering data from Federal Fiscal Year 2014. Retrieved 10/9/2017 from https://osep.grads360.org/#communities/pdc/documents/11987.
6. Wisconsin Department of Health Services. (2016). *Children's long term supports claims universe* [Data file]. Retrieved 10/10/2017. Analysis by OCMH. Data includes all claims for this analysis for all children receiving services in 2016. More information about allowable waiver services is available at https://www.dhs.wisconsin.gov/waivermanual/index.htm.
7. US Department of Education. (2016). Part C and Part B 619 Data Display: Wisconsin , Publication Year 2016 (revised).
8. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

Wisconsin Office of Children's Mental Health

FACT SHEET: Youth Justice

Intersection of Trauma, Mental Health, and Youth Justice

Trauma

- In general, youth with high Adverse Childhood Experiences (ACEs) are at greater risk of becoming youth offenders.[1] One study showed that 80% of violent youth offenders had an incarcerated household member (an example of an ACE),[2] which is nine times higher than the national average of 9%.[3]
- Early exposure to high levels of toxic stress can negatively impact executive functioning (e.g., reduced impulse control, difficulty delaying gratification, and challenges in weighing rewards and consequences) frequently leading to behaviors resulting in punitive measures.[4]

Mental Health

- Youth with depression are 70% more likely than their non-depressed peers to display violent behavior, including committing violent crimes.[5]
- Upon admission (also known as a "commitment") to Wisconsin's two juvenile correction facilities, Lincoln Hills or Copper Lake, assessments indicated that around two thirds of the youth had used mental health services prior to admission (2017).[6]
- In 2016, 76% of youth at Lincoln Hills or Copper Lake received mental health services such as dialectical behavior therapy, cognitive behavioral treatment, and sex offender or substance use disorder treatment.[7] Youth with more intensive mental health needs may be transferred to the Mendota Juvenile Treatment Center.

Wisconsin Youth Arrests are Decreasing

In 2015, 44,157 youth between the ages of 10 and 16 were arrested,[8] down 40% from 2011, though still higher than the national average (43 per 1,000 in Wisconsin compared to 14 per 1,000 in 2014).[9]

Wisconsin Detention Rates are Decreasing

Wisconsin's detention rate has decreased over the past twenty years, with a 51% reduction in the one-day count.[10] Detention is the placement of a youth accused of committing a crime into a secure facility pending hearing or disposition. In 2015, 762 youth from 18 years old and younger were detained, down 7% from 2013, and down almost 30% from the 2010.[11] The 2013 detention rate of 156/100,000 youth, was slightly lower than the national average of 173/100,000 youth.[12]

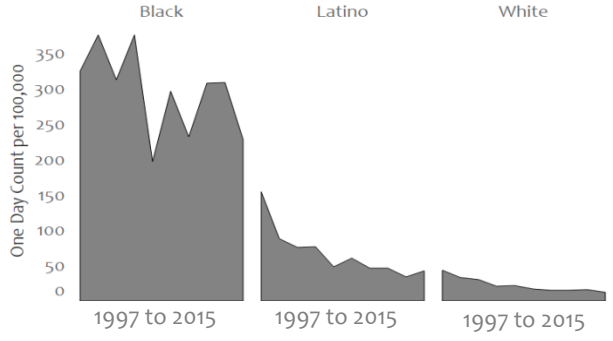
Wisconsin Detention by Race and Ethnicity are Decreasing

All races and ethnicities have had a reduction in detention rates between 2007 and 2015, with Hispanic and white youth experiencing the greatest decrease (29%), and black youth experiencing a more modest decrease (23%).[13]

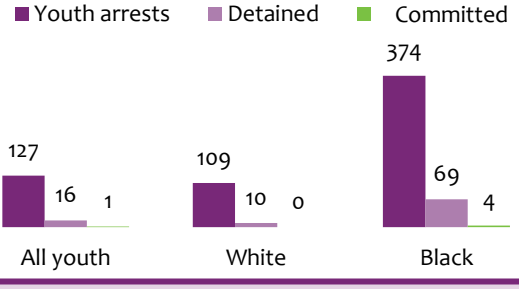
Wisconsin's Detention Rates Remain Racially Disproportionate

Of all youth arrested in 2015, about 21% of black youth and 9% of white youth were detained. Wisconsin had detention rate 50% higher than the national average for black youth (148 per 100,000), and detains black youth 19 times more often than white youth.[14]

Average one day youth commitment count, from 1997 to 2015[15]



Rate of arrest, detention, and incarceration in 2010, per 1,000 of Wisconsin's youth[16]



Key Findings

- Youth with high Adverse Childhood Experiences (ACEs) are at greater risk of becoming youth offenders.
- Black youth in Wisconsin are detained 19 times more than white youth, in contrast to the national trend of higher white youth detention rates.
- Wisconsin youth arrests, detentions, and incarcerations are decreasing, though Wisconsin continues to have a higher youth arrest rate than the national average.
- Overall rates of youth incarceration are going down, both for youth in the juvenile justice system, and youth in the adult correctional system.

Trends in Youth Incarceration[17]

Incarceration is the long-term hold of those found guilty of a crime. In Wisconsin, youth are incarcerated, or "committed" to one of two state facilities, Lincoln Hills (for males) and Copper Lake (for females), or at Mendota, a state run mental health facility.

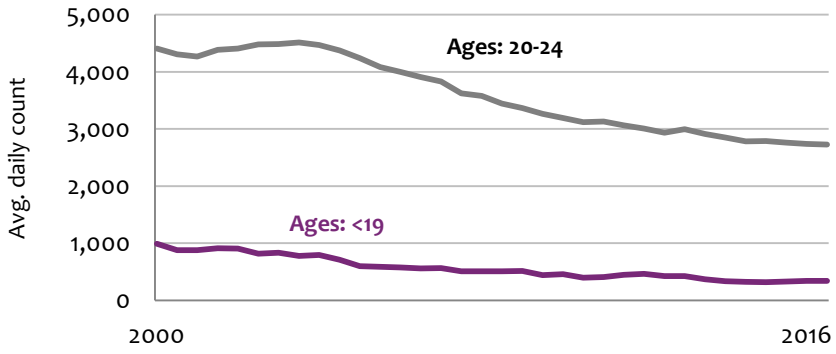
- On 6/30/2017, the state facilities housed 178 youth in Lincoln Hills and Copper Lake Schools.
- These youth facilities had 166 new commitments in 2016.
- More youth of color are committed than white youth (see table to the right).
- The average daily population for Wisconsin youth who are committed decreased by 25% from 408 in 2010 to 307 in 2014.[19]

Racial makeup of all commitments to Division of Juvenile Correction facilities in 2016[18]

Race	Percent of Commitments	Percent of WI Population
Lincoln Hills School (Males)		Male <18
American Indian	3%	2%
Asian/Pacific Islander	1%	4%
Black	71%	11%
White	26%	84%
Copper Lake School (Females)		Female <18
American Indian	12%	2%
Black	50%	11%
White	38%	83%

Youth Incarcerated as Adults[20]

Wisconsin had a 40% decrease over the last ten years in daily counts for youth (<19) incarcerated in the adult system. Young adults between 20 and 24 have had a 30% decrease (see line graph below).



Recidivism

The Department of Corrections defines recidivism as individuals with a prior offence who commit a new crime and return to corrections. Recidivism is high among youth (<18) commitments. For Wisconsin youth released in 2011:[21]

- 36% returned to corrections (first year)
- 45% returned to corrections (second year)
- 63% returned to corrections (third year)

Nationally, almost half of incarcerated youth return within three years.[22] For young adults 18 to 29, 20% return in one year, and 40% return after three years.[23]

References

1. Fox, Bryanna Hahn, et al. (2015) *Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. Child Abuse & Neglect* 46: 163-173.
2. IBID
3. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. (2016). *National Survey of Children's Health* [Data query]. Retrieved 10/31/2017 from www.childhealthdata.org.
4. Shonkoff, J. P. et al. (2012). The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129(1), e232-e246.
5. Yu, R. et al. (2017). Depression and Violence in Adolescence and Young Adults: Findings From Three Longitudinal Cohorts. *Journal of the American Academy of Child & Adolescent Psychiatry*.
6. WI Department of Juvenile Corrections. (2017). *WI DJC Internship in Health Services Psychology.* Madison, WI. Retrieved from doc.wi.gov.
7. Personal communication from the WI Department of Corrections, Division of Juvenile Corrections, July 2017.
8. Kids Count. (2010-2015) *Juvenile arrests* [Data table]. Retrieved 11/6/2017 from http://datacenter.kidscount.org/data/.
9. Puzzanchera, C. and Kang, W. (2017). "*Easy Access to FBI Arrest Statistics 1994-2014*" Online. Available: http://www.ojjdp.gov/ojstatbb/ezaucr/
10. Kids Count. (2010-2015) *Youth residing in juvenile detention, correctional, and/or residential facilities* [Data table]. Retrieved 10/5/2017 from http://datacenter.kidscount.org/data/.
11. Burns Institute. (1997-2015). *Detention Rates* [Data table]. Retrieved on 6/30/2017 from http://data.burnsinstitute.org/. Data from the US Office of Juvenile Justice and Delinquency Prevention, which includes only a subset of Wisconsin counties.
13. Kids Count. (2010-2015) *Youth residing in juvenile detention, correctional, and/or residential facilities* [Data table].
14. Burns Institute. (1997-2015). *Detention Rates* [Data table].
15. IBID
16. IBID
17. Personal communication from the WI Department of Corrections, Division of Juvenile Corrections, July 2017.
18. IBID
19. WI Department of Corrections. (2015). *DJC Annual Report 2014.* Division of Juvenile Corrections, Madison, WI. Retrieved 10/30/2017 from https://doc.wi.gov/Documents/AboutDOC/JuvenileCorrections/DJCAnnualReport2014.pdf.
20. WI Department of Corrections. (2017). *Prison Point-in-time Populations, Table 5* [Data table]. Retrieved on 10/5/2017 from https://doc.wi.gov/Pages/DataResearch/PrisonPointInTime.aspx Data includes youth and young adult under 24 who are tried as adults.
21. WI Department of Corrections. (2016). *DJC Recidivism 2000-2013* [Data table].
22. US Department of Education. (2016). *FACT SHEET: Reducing Recidivism for Justice-Involved Youth.* Washington, DC: Press Office. Retrieved 10/23/2017 from https://www.ed.gov/news/press-releases/fact-sheet-reducing-recidivism-justice-involved-youth.
23. WI Department of Corrections. (2013-2015). *Recidivism after Release from Prison* [Data file]. Data represents follow up rates to crimes committed in 2012-2014. Retrieved 9/29/2017 from https://doc.wi.gov/Pages/DataResearch/RecidivismDashboard.aspx. Only includes individuals tried as adults, whose age could be under 18, not those from the WI Division of Juvenile Corrections.

Wisconsin Office of Children's Mental Health

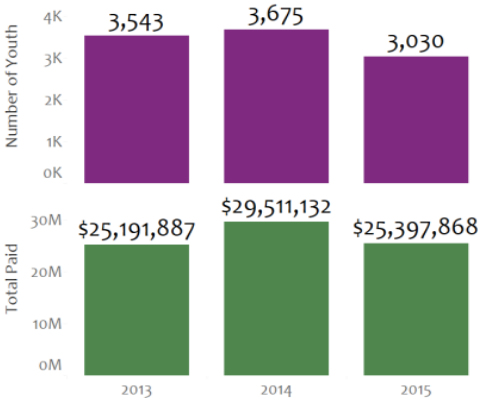
FACT SHEET: Youth Psychiatric Hospitalizations, Readmissions, and Emergency Detentions

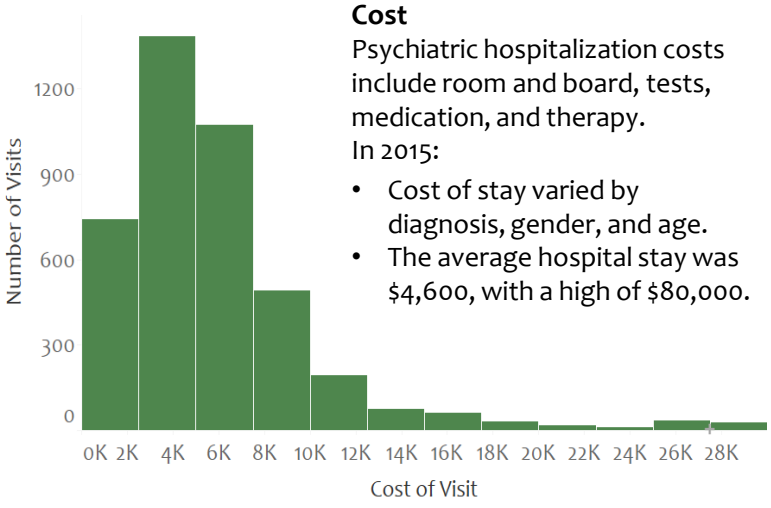
Psychiatric hospitalizations are used in times of intense need, when a child is thought to be a harm to him/herself or others.[1]

Wisconsin Youth Hospitalizations (2015):

- Psychiatric hospitalizations for 3,030 children on Medicaid occurred at Wisconsin's 23 state and private hospitals at a cost of approximately $25 million.
- Children's psychiatric hospitalizations decreased with 15% fewer children hospitalized in 2015 than 2014.
- Of the children who received any mental health services from Medicaid in 2015, 8.4% were hospitalized.
- The top two diagnoses for hospitalizations were depression (36%) and other mood disorders (23%).
- Girls and boys had the most hospitalizations during adolescence.
- Children were hospitalized for an average of 6 days each stay, which is higher than the national average of 4.5 days.[2]
- Children spent an average of seven days in the hospital, and about 20% of children had more than one stay each year.
- Children living in high poverty counties had the highest rates of psychiatric hospitalizations at 76 per 100,000 compared to 47 per 100,000 in the counties with the lowest poverty.[3]

Psychiatric hospitalizations: cost and count of children covered by Medicaid

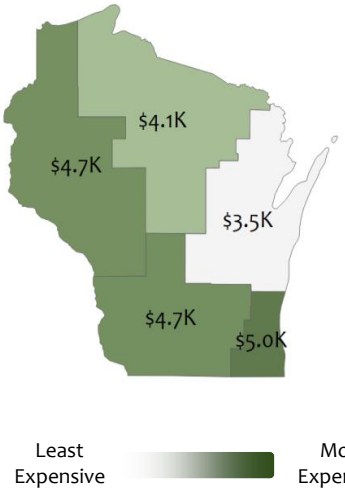




Cost

Psychiatric hospitalization costs include room and board, tests, medication, and therapy.
In 2015:

- Cost of stay varied by diagnosis, gender, and age.
- The average hospital stay was $4,600, with a high of $80,000.



Geography

Counties with a population over 80,000 (Dane, Milwaukee, and Waukesha) account for 40% of the hospitalization costs, while serving only 32% of Wisconsin's children (2015).

Many counties are working to reduce hospitalizations and some have decreased as much as 30% between 2013 and 2015.

Key Findings

- Emergency Detentions are on the rise, e.g., Wisconsin's state facility reached 200% capacity (point in time) in 2017.
- Youth on Medicaid had fewer psychiatric hospitalizations in 2015 compared to the previous two years, though the number of Emergency Detentions almost doubled during that same time period.
- Psychiatric hospitalizations are expensive, costing almost $5,000 per stay. As a comparison, Medicaid mental health providers could provide over a year of outpatient therapy for less money.

Parent and Youth Voice[8]

Some parents report that initiating an Emergency Detention to Winnebago Mental Health Institute (WMHI) seems like the most expedient way to access mental health services for their children.

Families report receiving needed follow-up care from WMHI staff, such as enrollment in Medicaid and links to additional services such as wraparound programs.

Youth Psychiatric Hospitalizations, Readmissions, and Emergency Detentions (page 2)

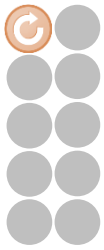
Readmission is defined as reentering the hospital within 7, 30, or 365 days of discharge. Lowering readmission rates is a quality metric approved by the Agency for Healthcare Research and Quality, among others.[5]

Nationally, readmission rates vary based on the health plan and population and are typically viewed negatively due to implications that the initial hospitalization and after care planning was ineffective.[4]

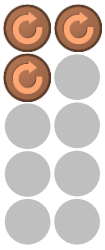
In 2015, **11% of Wisconsin children who were hospitalized for psychiatric reasons were readmitted within 30 days (N=325),** and **31% of children were readmitted within a year.**

The percent of Wisconsin children readmitted into a hospital within a year has increased almost 20% from 2013 to 2015.

One in 10 children on Medicaid is readmitted to the hospital for psychiatric services *within 30 days.*



Three in 10 children on Medicaid are readmitted to the hospital for psychiatric services *within one year.*

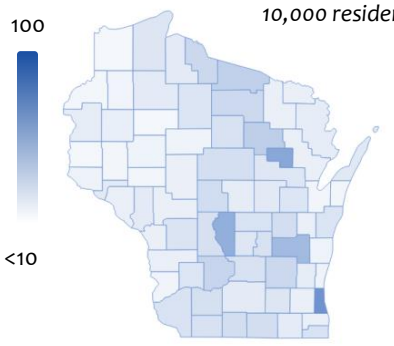


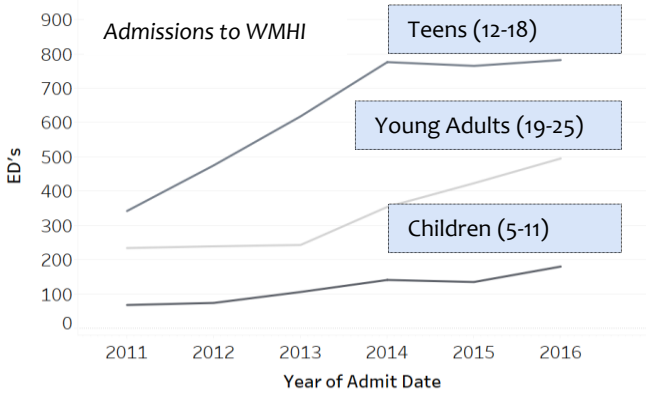
Emergency Detention is a type of psychiatric hospitalization bound by legal status and established only when youth experience severe mental distress and are at risk of harming themselves or others. Many youth under an emergency detention are taken to Winnebago Mental Health Institute (WMHI), a state-run mental health facility.[6]

Emergency Detention (ED) Admissions[7]

- The average monthly ED admissions have steadily increased since 2011.
- Teens are most likely to be admitted (see line graph), but the number of young adult admissions has more than doubled in the last three years (250 to 500 per year).
- The number of children (ages 5-11) admitted to WMHI has increased 165% since 2011, and was up 33% in 2016. This is the most growth for any age group.
- WMHI reached their highest historical youth admissions (e.g. 200% of capacity) in May of 2017. Causes are believed to be related to increasing severity of youth's mental health needs as well as the 2010 elimination of youth ED admissions to Mendota Mental Health Institute.

WMHI Youth (5-17) Emergency Detention Rate per 10,000 residents (2015)[7]





References

1. Wisconsin Department of Health Services. (2012-2015). *Medicaid claims spending* [Data file]. Received 3/1/2017 from the Division of Medicaid Services. This analysis includes psychiatric hospitalizations for children under age 18, designated by a mental health diagnosis and a DRG indicating mental health. Claims from 2015 unless otherwise stated. Geographic analyses are based on a child's county of residence, not the location of the hospital.
2. Case, Brady G., et al. (2007). *Trends in the inpatient mental health treatment of children and adolescents in US community hospitals between 1990 and 2000. Archives of general psychiatry* 64.1 :89-96.
3. Poverty levels are calculated by quartile, data from 2015 Medicaid claims. (See Reference 1).
4. James, Sigrid, et al. (2010). *Post-discharge services and psychiatric rehospitalization among children and youth. Administration and Policy in Mental Health and Mental Health Services Research* 37.5: 433-445.
5. National Committee for Quality Assurance (NCQA). (2015). *HEDIS 2016: Healthcare Effectiveness Data and Information Set.* Vol. 1, narrative. Washington DC.
6. Data on Emergency Detentions is only available for those that happen at WMHI and in Milwaukee County. A presumed number of ED's happen at other facilities around the state.
7. Wisconsin Department of Health Services. (2011-2016). *WMHI Admission Records* [Data file]. Received 9/12/2017 from the Division of Care and Treatment Services. Data from WMHI Admission Records, averaged from 2011 to 2016. Milwaukee data from the Milwaukee County Behavioral Health Division PCS Records for children discharged to a hospital, averaged from 2013 to 2016, received 8/24/2017.
8. Children's Mental Health Collective Impact Parent and Youth Partners. For more information visit https://children.wi.gov.

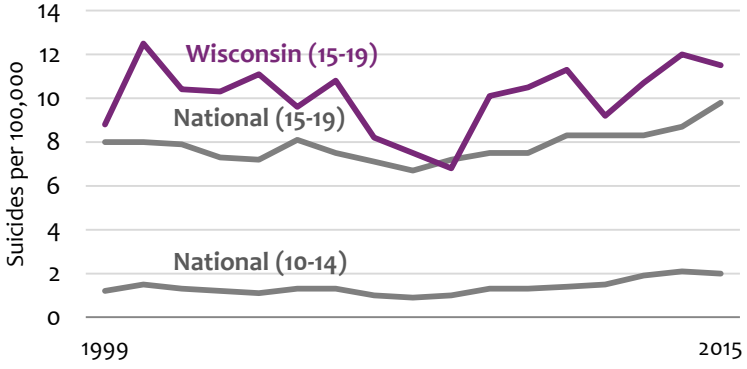
Wisconsin Office of Children's Mental Health

FACT SHEET: Youth Suicide and Self Harm

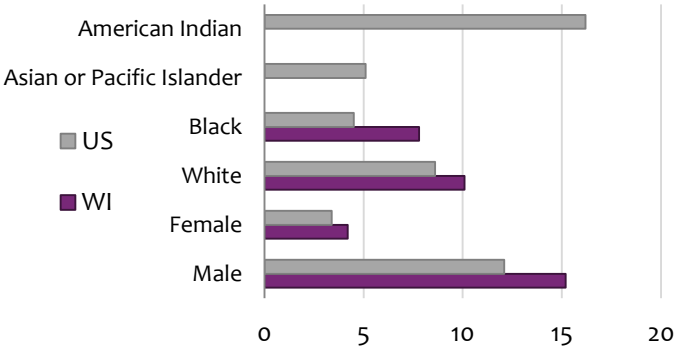
Youth Suicide[1,2]

- Nationally, 9.8 per 100,000 youth (n=2,061) aged 15-19 died by suicide (2015).
- *More teen males complete suicide than females*. In 2015, the national rate of teen male suicide was 18.1 per 100,000, and for females was 5.1 per 100,000.
- *Nationally and in Wisconsin suicide is increasing.* Between 2007 and 2015, the national youth suicide rate for youth ages 15-19 increased by 30% for males and doubled for teen females. In Wisconsin, youth suicide rates have doubled from 2007 to 2015 (see line graph below).
- Wisconsin and the nation show an upward trend in suicide rates for 15-19 year olds.[3] The suicide rates for Wisconsin 10-14 year olds are too low to be stable and cannot be compared to national data.[4]

Wisconsin[5] and US[6] suicide rates by age.



Wisconsin[7] and US[8] youth (15-19) suicide rate breakdown per 100,000(2005-2015)



Key Findings

- National and Wisconsin youth suicide rates have been rising since 2007.
- Wisconsin consistently has higher youth suicide rates than the national average.
- Wisconsin's LGB students are 3.5 times more likely to attempt suicide.
- Self harm rates have increased, particularly for Wisconsin females ages 15-19.
- Wisconsin youth have protective factors such as adult mentors and community supports including access to QPR, and text help lines.

Risk Factors

Bullying

- Bullying may impact a child's social and emotional development and can be a risk factor for mental illness.[9] Nationally in 2015, 26% of females and 20% of male high school students were bullied.[10] In Wisconsin, 28% of females and 20% of males and were bullied in 2017.[11]

Family History

- Youth with parents who experience mental illness, or a parent who died by suicide are more likely to die by suicide.[12] In 2016, 7.8% and 8.7% of children nationally and Wisconsin , respectively, lived with a parent with mental illness.[13]

Mental Illness or Drug /Alcohol Use[14]

- A 2003 study showed that 90% of older youth who died by suicide had some documented mental illness.
- Drug and alcohol use is correlated with suicidality.

Sexual Orientation

- LGBTQ+ youth are more likely to experience depression, alcohol abuse, victimization, all of which can lead to suicidal behavior.[15,16] Wisconsin's LGB students were 3.5 times more likely to attempt suicide (2016).[17]

Protective Factors

Access to Treatment

- Access to mental health care and specific cognitive therapies can decrease suicide risk.[18,19]
- Nationally, in 2016, 62% of children with an emotional, behavioral or developmental condition received treatment. Wisconsin and surrounding states have a slightly higher rate, though not statistically different from the U.S. average.[20]

Means Restriction

- Nationally, 43% of suicides in 15-19 year olds were by suffocation, 42% by firearm, and 6% by drug poisoning.[21] Reducing access to guns and medications is advised for people with suicidal thoughts.

Social Support

- Being connected to family, community, and other social supports can protect and strengthen resilience in young people.[22,23]
- 94.2% of Wisconsin youth have one or more adult mentor, a percentage which remains high among all racial groups.[24]
- Community-based prevention and training programs such as Question Persuade Refer (QPR), provide support and resources to youth in crisis.

Suicide Warning Signs

- Talking about wanting to die, feeling hopeless, having no purpose, or feeling trapped.
- Increasing use of alcohol or drugs.
- Extreme mood swings or change in social interactions or sleep patterns.

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone.
- Remove firearms, alcohol, drugs, or sharp objects.
- Call your local crisis intervention hotline or the National Suicide Prevention Lifeline at 800-273-TALK or text "HOPELINE" to 741741.

Self Harm may or may not be related to suicidal ideation or intention, but similarly represents mental distress and possible underlying depression, anxiety, isolation, substance use, or suicidal ideation. Self harm may also be related to childhood abuse or bullying.[25]

- In 2016, 38% of Wisconsin's female high school students reported feeling sad and hopeless for two or more weeks, up from 26% in 2011.[26]
- In 2017, 8.9% of male and 24.1% of female high school students reported purposefully hurting themselves without wanting to die. No change was seen from 2013.[27]

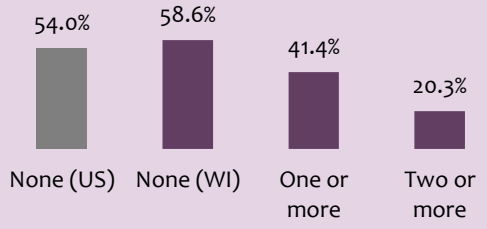
National and Wisconsin self harm hospitalizations are increasing.

- The national rate of self harm hospitalizations for all youth (under 18) has increased, with the rate for females doubling between 2009 and 2015, to a rate of 218 per 100,000.[28] This same increase was seen in Wisconsin females.
- The Wisconsin rate is lower than the national rate. In 2014, the rate of Wisconsin self harm hospitalizations in females under 18 was 158/100,000, compared to 207/100,000 nationally.[29]
- Rates for specific groups in Wisconsin are higher than average. The highest rates of self harm were seen in females between the ages of 15-17 years, at 376/100,000 in 2014.[30]

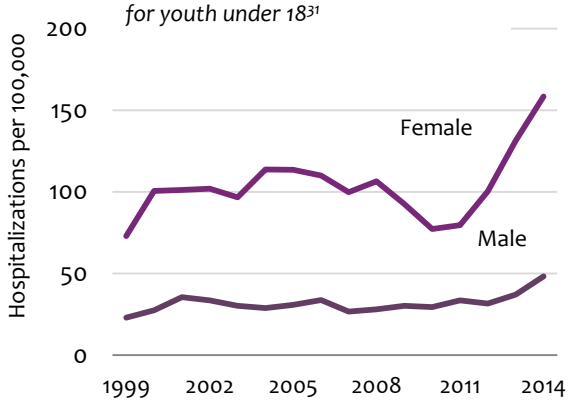
Adverse Child and Family Experiences[32]

Physical, sexual, and emotional abuse, as well as other ACEs, can lead to suicide risk factors such as mental illness, substance use, or social isolation.

Prevalence of Adverse Family Experiences in Wisconsin's children (2016)



Wisconsin self harm hospitalizations for youth under 18[31]



References

1. *QuickStats:* Suicide Rates for Teens Aged 15–19 Years, by Sex — United States, 1975–2015. MMWR Morb Mortal Wkly Rep 2017;66:816. DOI: http://dx.doi.org/10.15585/mmwr.mm6630a6.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. (1999-2015). *Underlying Cause of Death 1999-2015* [Data file]. Retrieved 10/9/2017 at http://wonder.cdc.gov/ucd-icd10.html.
3. Centers for Disease Control and Prevention, National Center for Health Statistics. (1999-2015). *Underlying Cause of Death 1999-2015* [Data file]. Retrieved 10/9/2017 at http://wonder.cdc.gov/ucd-icd10.html.
4. Wisconsin Department of Health Services. (2015). WISH, *Wisconsin Mortality Module* [Data file]. Retrieved 9/29/2017 from https://wish.wisconsin.gov.
5. IBID
6. CDC. (1999-2015). Underlying Cause of Death 1999-2015 [Data file].
7. Wisconsin Department of Health Services. (2015). WISH, *Wisconsin Mortality Module* [Data file].
8. CDC. (1999-2015). Underlying Cause of Death 1999-2015 [Data file].
9. CDC. (2017). *Bullying Research*. Retrieved 10/26/2017 from cdc.gov.
10. Centers for Disease Control and Prevention. (2015). *Youth Risk Behavior Survey* [Data file]. Retrieved 8/8/2017 from nccd.cdc.gov/youthonline.
11. Centers for Disease Control and Prevention. (2017). *Wisconsin 2017 Youth Risk Behavior Survey Summary Tables*. Retrieved 11/7/2017 from https://dpi.wi.gov/sspw/yrbs.
12. Gould, M. S., Greenberg, T. E. D., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: a review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(4), 386-405.
13. Child and Adolescent Health Measurement Initiative (CAHMI), Data Resource Center for Child and Adolescent Health. (2016). National Survey of Children's Health [Data query]. Retrieved 10/31/2017 from www.childhealthdata.org.
14. Gould et. al. (2003).
15. IBID
16. Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., & Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, 49(2), 115-123.
17. CDC. (2017). *Wisconsin 2017 Youth Risk Behavior Survey Summary Tables*.
18. Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide.* Newton, MA: Education Development Center, Inc.
19. Xavier, A., Cunha, M., & Pinto Gouveia, J. (2015). Deliberate self-harm in adolescence: The impact of childhood experiences, negative affect and fears of compassion. *Revista de Psicopatología y Psicología Clínica*, 20(1), 41-49.
20. CAMHI. (2016). National Survey of Children's Health [Data query].
21. Centers for Disease Control and Prevention, Injury Center. (2001-2015). *WISQARS Nonfatal Injury Data* [Data file]. Retrieved 10/20/2017 from cdc.gov.
22. Gould et. al. (2003).
23. SPRC. (2011).
24. CDC. (2017). *Wisconsin 2017 Youth Risk Behavior Survey Summary Tables*.
25. Xavier et. al. (2011).
26. CDC. (2017). *Wisconsin 2017 Youth Risk Behavior Survey Summary Tables*.
27. IBID
28. CDC. (2001-2015). *WISQARS Nonfatal Injury Data* [Data file].
29. Wisconsin Department of Health Services. (2015). WISH, *Wisconsin Injury Hospitalization Module* [Data file]. Retrieved 9/29/2017 from https://wish.wisconsin.gov.
30. IBID
31. IBID
32. CAMHI. (2016). National Survey of Children's Health [Data query]. *Adverse Family Experiences are similar to Adverse Childhood Experiences, but measured for children under 18.*

CONCLUSION

The primary goals of this report are to outline the efforts undertaken by the OCMH and to provide current data regarding the well-being of children and youth in Wisconsin. This report summarizes the many activities of the OCMH over the last year, including its efforts to support the Children's Mental Health Collective Impact and workgroups, detailing funding changes that stand to positively impact children's mental health, and outlines how OCMH efforts in the coming year will serve to further its mission. The updated data for the 48 child well-being indicators, along with the 15 fact sheets provide an overview of how the needs of children and families are currently being met by the programs and services available in Wisconsin.

MANY THANKS TO WISCONSIN'S COLLECTIVE IMPACT PARTNERS

Tina Buhrow (Chippewa County) serves on the following:

- Co-chair Children's Mental Health Collective Impact (CMHCI) Executive Council
- Co-chair CMHCI Trauma-Informed Care Workgroup
- Co-chair Chippewa County Children, Youth & Families Committee
- Wisconsin Trauma Project Co-Facilitator (in training)
- Crisis Stabilization Provider
- Parent Advisory to School Mental Health Initiative

We depend on Tina to reminds us that we're operating on 'Kids Time.'

Michael is a thinker. He contemplates topics and is careful to provide input only after careful consideration.

When Michael speaks, people listen.

Michael Bostrom (Chippewa County) attends school, works, and represents the viewpoint of young adults as a member of the Children's Mental Health Collective Impact.

Kimberlee Coronado (Waukesha County) serves on the following:

- Waukesha County TIC Partnership/Collective Impact Committee
- Waukesha's Special Services Advisory Committee
- Waukesha County Children's Mental Health Committee
- Co-chair of the CMHCI Executive Council and the CIPs meetings
- CMHCI Access Workgroup and TIC policy workshop moderator
- DHS Rule 40 Day Treatment Advisory Committee
- Governor's Wisconsin Council on Mental Health
- Governor's Committee for People with Disabilities
- DCF Children with Disabilities in the Child Welfare System workgroup

Kimberlee ensures that our pace allows for everyone to have input.

She comes to the table ready to learn and takes this knowledge to transform as many child-serving systems as she can.

Charisse is one of our newest CIP members. She brings years of experience improving child serving systems.

Charisse Daniels (Jefferson County) serves on the following:

- Children's Mental Health Collective Impact (CMHCI) Executive Council Committee
- Mental Health Practitioner and Team Support Coordinator at Minnesota CarePartner
- Supervisor of supervised visitations at WI Families in Transition Services

Tabitha DeGroot (Brown County) serves on the following:

- Co-chair of the Children's Mental Health Collective Impact (CMHCI) Executive Council Committee
- Oneida Nation – Coordinated Services Teams (CST) Committee
- Parent 2 Parent Mentor

Tabatha brings a youthful, fresh energy to the group that revitalizes and energizes us.

Her contributions and leadership grow with each meeting.

Bob reminds us of the importance of substance use issues, and the impact on families' well-being.

Bob Fredericks (Dane County) serves on the following:

- Recovery Implementation Task Force (RITF) for Wisconsin
- Co-chair of the Health Care Integration sub-committee of the RITF
- Children's Mental Health Collective Impact Partner
- Parent Peer Specialist Workgroup

Whitney Holt (Polk County) serves on the following:

- Children's Mental Health Collective Impact (CMHCI) Executive Council Committee
- Mental Health Practitioner and Team Support Coordinator at Minnesota CarePartner
- Supervisor of supervised visitations at Wisconsin Families in Transition Services

Whitney brings a unique perspective, including that of a provider working within the mental health system, and as a parent navigating children's mental health services.

Robert has a wonderful ability to say things in ways that relate to many people.

Robert Kaminski (Outagamie County) serves on the following:

- Facilitator for NAMI Fox Valley Family Support Group for Parents and Caregivers of School Age Children
- Children's Mental Health Collective Impact (CMHCI) Executive Council Committee
- Co-chair of the CMHCI Access Workgroup
- Children Come First (CCF) Advisory Committee
- DHS Rule 40 Day Treatment Advisory Committee

Zofia Kaminski (Outagamie County) attends school, working towards her bachelor degree in social work and represents the viewpoint of young adults as a member of the Children's Mental Health Collective Impact.

Zofia brings a positive and hopeful perspective, despite having faced many challenges within the current mental health system.

Corbi keeps us honest about the language we use. She reminds us of the importance of being respectful and thoughtful in the words we say and how we say them.

Corbi Stephens (Marquette County) serves on the following:

- Children's Mental Health Collective Impact (CMHCI) Young Adult Partner
- Co-chair of the CMHCI CIPs
- Co-Chair of the CMHCI Resilience Committee
- Marquette County CCS Coordinating Committee

Alison Wolf (Ozaukee County) serves on the following:

- Parent Peer Specialist, Southeast Regional Coordinator and Intake Specialist, and Children Come First Conference Coordinator for Wisconsin Family Ties
- Children's Mental Health Collective Impact (CMHCI) Parent Partner
- CMHCI Resilience workgroup member
- Shared Resource Group for the Wisconsin Alliance for Infant Mental Health
- Board Member Helping Hands Healing Hooves, Ozaukee County
- Board Member for The Gathering, future respite care facility in Ozaukee County
- Partnership for Children's Mental Health Committee in Waukesha County
- Character Counts Mental Health Committee Port Washington/Saukville School District and Community
- Youth Mental Health First Aid Trainer
- Trauma-Informed Care Champion

Alison provides centered and wise insights. Her experience is expansive and includes advocacy within child welfare, schools, and county mental health systems.

Joe reminds us to be intentional in our work and keeps us focused on the mission and goals. He brings experience from the private sector to conversations about the public mental health system.

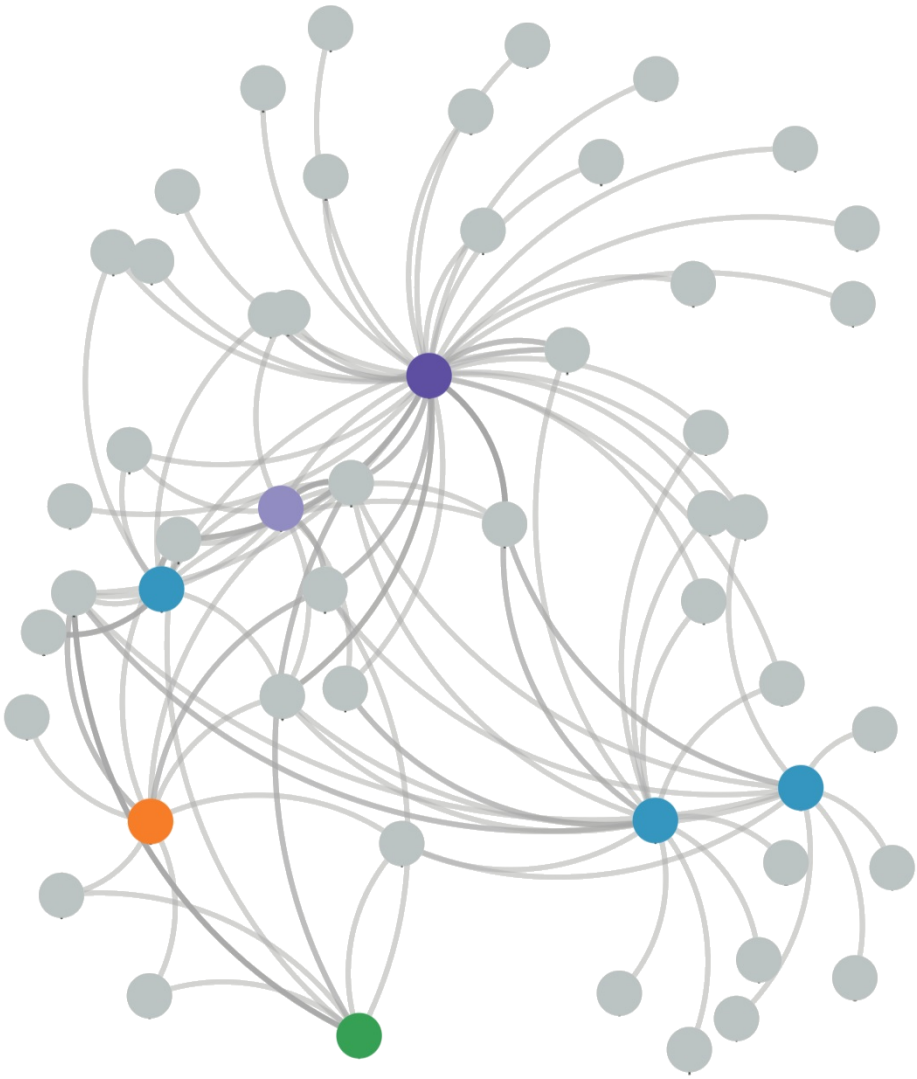
Joe Zeimentz (Dane County) serves on the following:

- Children's Mental Health Collective Impact (CMHCI) Executive Council
- OCMH Research Advisory Council

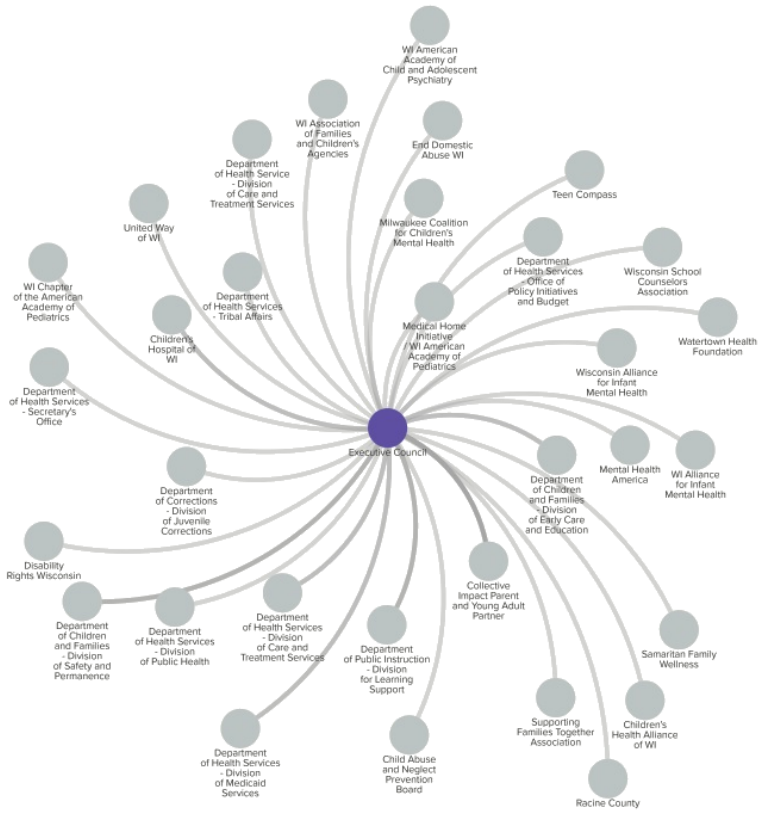
MANY THANKS TO WISCONSIN'S COLLECTIVE IMPACT MEMBERS AND STAKEHOLDERS

Network Mapping: The Big Picture

The network map below represents the people and organizations who have contributed time and expert guidance to the Children's Mental Health Collective Impact initiative and the Office of Children's Mental Health. The following pages separate this network into activity clusters.

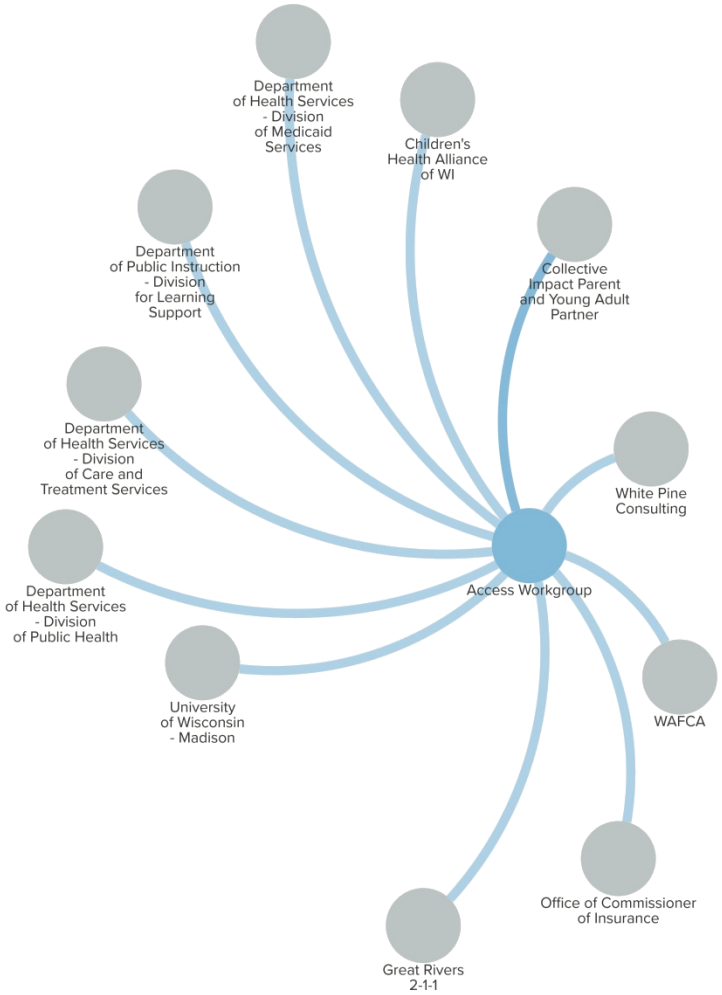


Thanks to the CHMCHI Executive Council Members



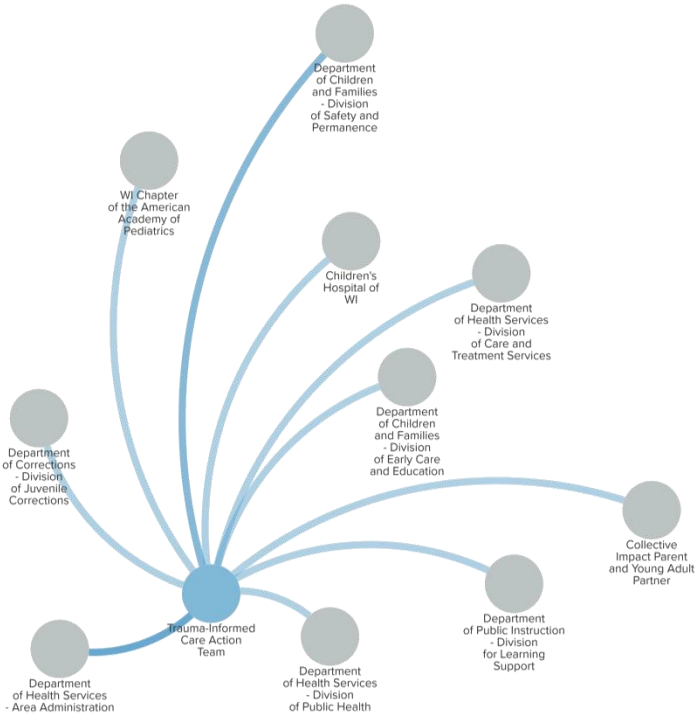
Alison Wolf
Amanda Reeve
Arianna Keil
Bonnie MacRitchie
Carrie Finkbiner
Charisse Daniels
Charlene Mouille
Cheryl Jatczak-Glenn
Cody Warner
Corbi Stephens
Elizabeth Hudson
Fredi Bove
Gail Nahwahquaw
Holly Stoner
Jackie Hartley
Jennifer Hammel
Jessica Nichols
Jillian Clemens
Joann Stephens
Joe Zeimentz
Jon Hoelter
Joyce Allen
Judie Hermann
Karen Ordinans
Karissa Vogel
Kayla Sippl
Kia LaBracke
Kim Eithun
Kimberlee Coronado
Lana Nenide
Leah Jepson
Leah Ludlum
Linda Hall
Linda McCart
Lynne Morgan
Micheal Bostrom
Monica Wightman
Phyllis Greenberger
Rachel Ninham
Rebecca Collins
Rebecca Murray
Rob Kaminski
Robert Fredricks
Romilia Schlueter
Scott Stoner
Shelby McCulley
Stacy Eslick
Tabitha DeGroot
Tammi Kohlman
Terri Enters
Tiffany Radditz
Tina Buhrow
Tina Crave
Tracy Oerter
Whitney Holt
William Swift

Thanks to the CHMCHI Access Workgroup Members



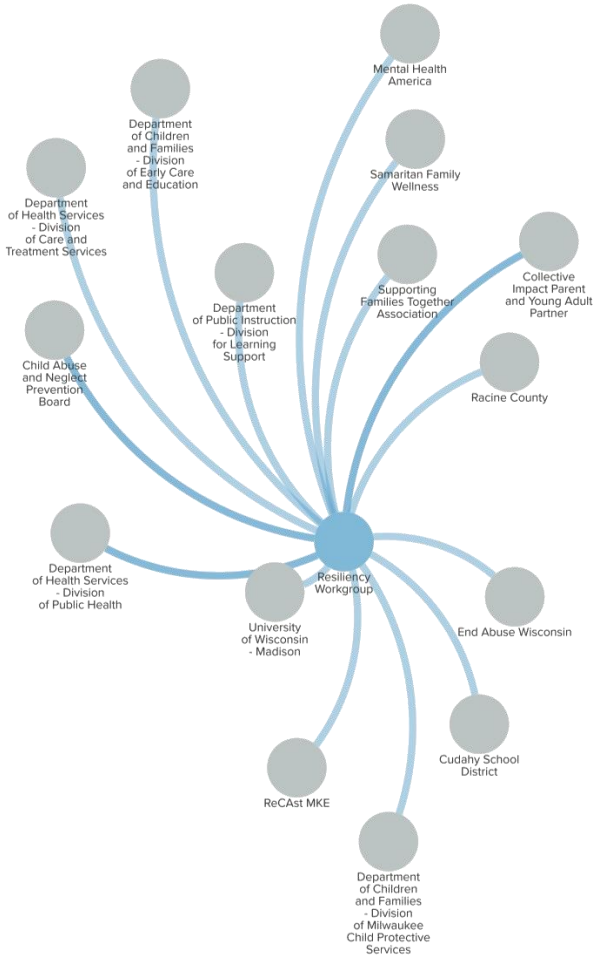
Barbara McPeak
Cheryl Jatczak-Glenn
Diane Dambach
Gregg Curtis
Kimberlee Coronado
Linda Hall
Mariah Geiger
Naomi Kowald
Phil Robinson
Robert Kaminski
Teresa Steinmetz
Tim Markle

Thanks to the CHMCHI Trauma-Informed Care Action Team



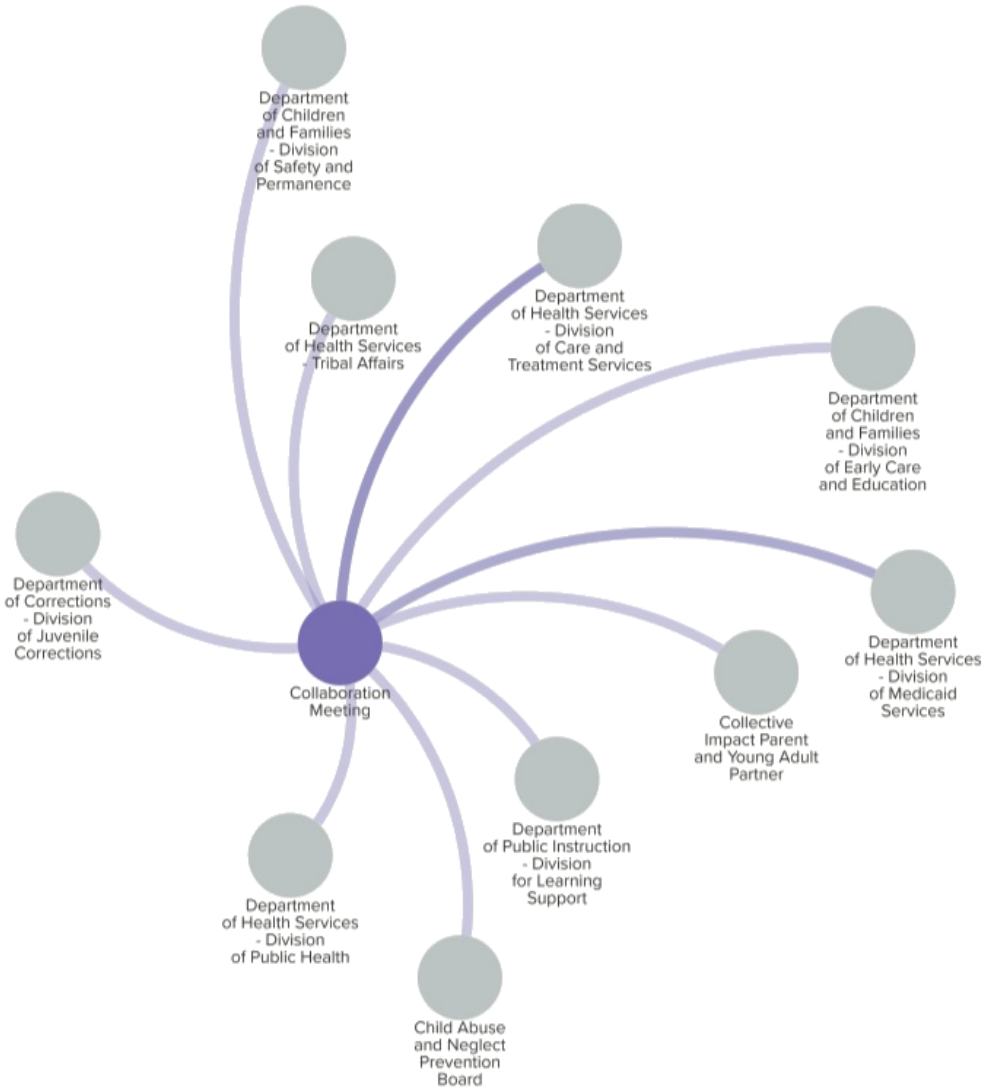
Amy Bell-Ferries
Ann Rolling
Donna Burns
Elizabeth Dehling
Emily Tofte
Jessica Nichols
Joanette Robertson
Kia LaBracke
Kristin Burki
Michelle Buehl
Michelle Larson
Robin Matthies
Robin Raj
Tina Buhrow

Thanks to the CHMCHI Resiliency Workgroup Members



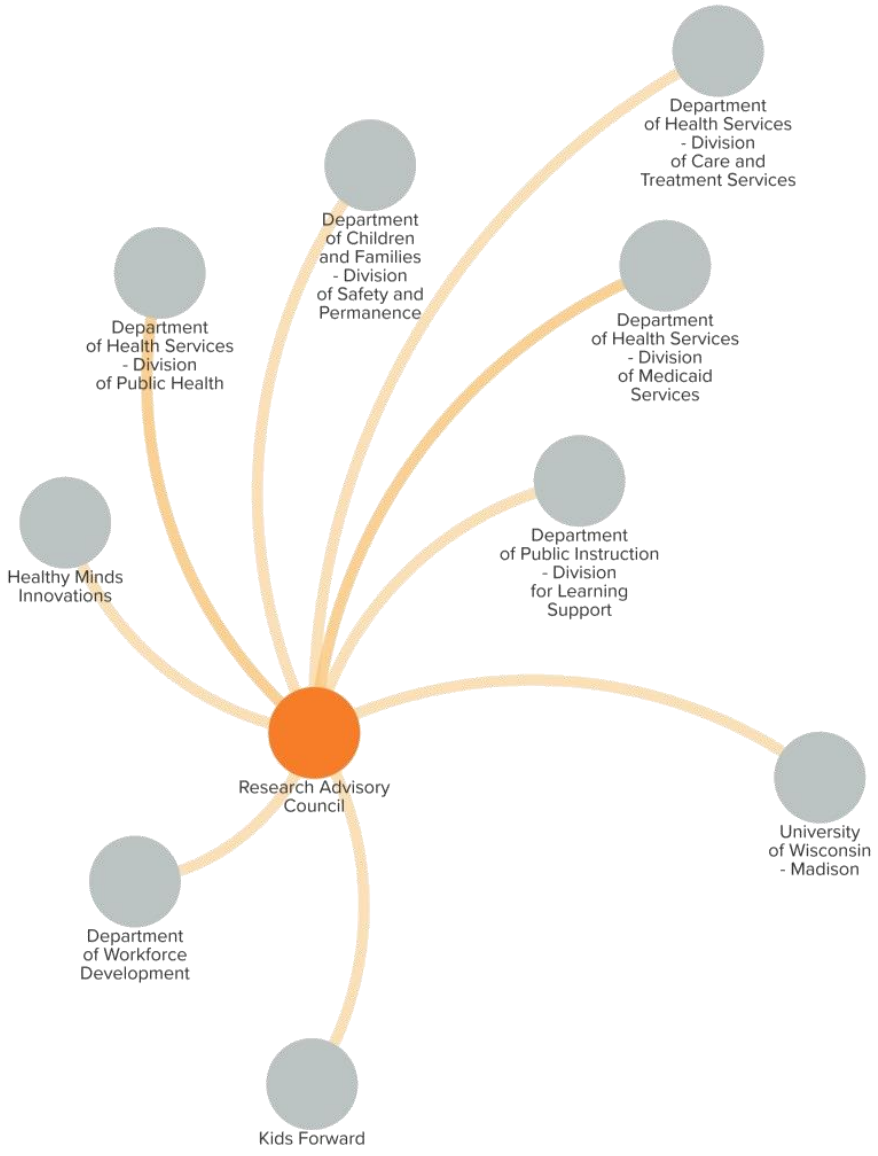
Alison Wolf
Cody Warner
Corbi Stephens
Jackie Hartley
Jenell Lorek
Jeremy Triblett
Jillian Clemens
Julie Poehlmann-Tynan
Laurice Lincoln
Leah Jepson
Monica Wightman
Peggy Helm-Quest
Rebecca Mather
Rebecca Murray
Rebecca Wigg-Ninham
Robin Matthias
Romilia Schlueter
Scott and Holly Stoner

Thanks to the State Agencies Collaboration Members



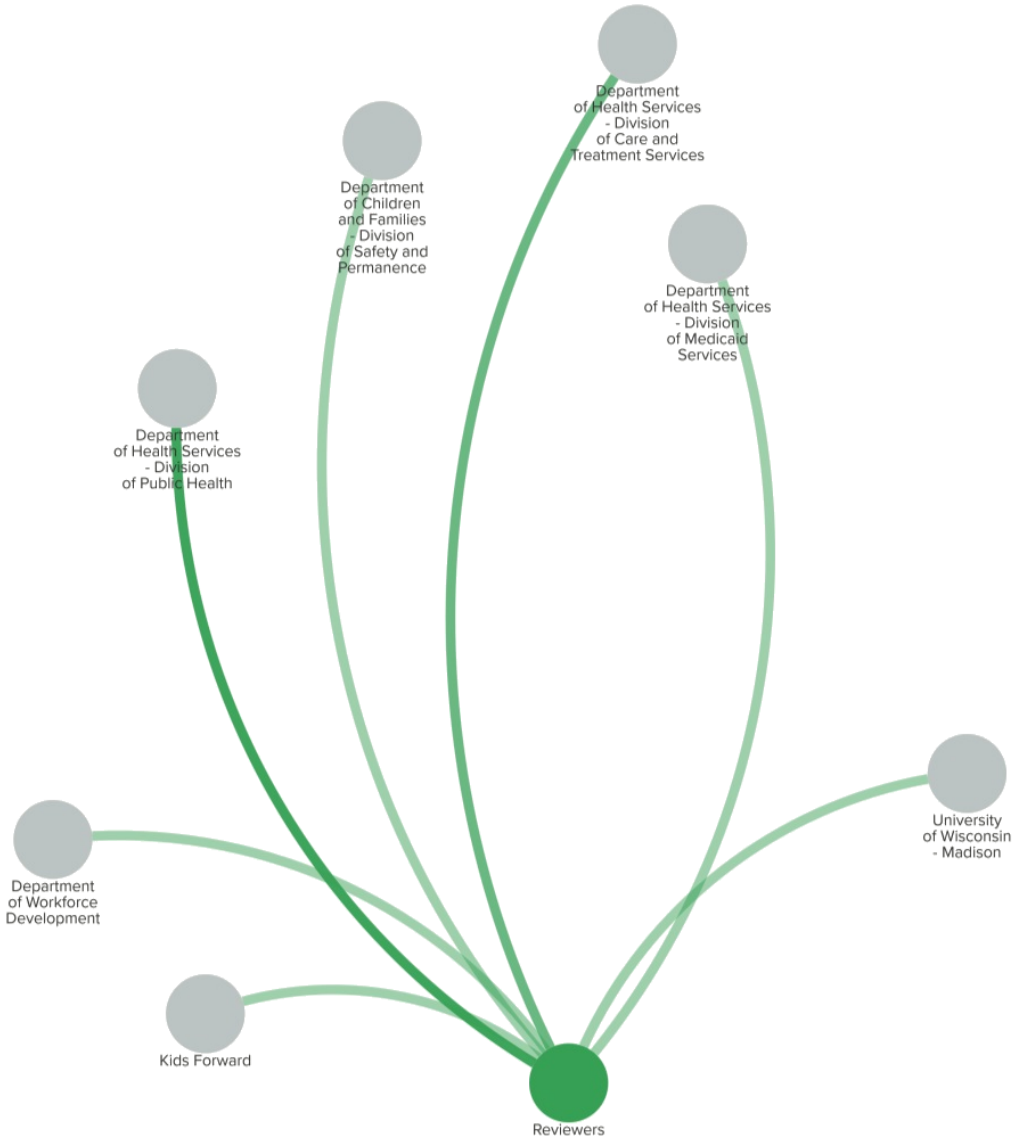
Amanda Reeve
Becky Collins
Camille Rodriguez
Cheryl Jatczak-Glenn
Deb Rathermel
Elizabeth Hudson
Fredi Bove
Gail Nahwahquaw
Holly Audley
Joann Stephens
Joyce Allen
Kim Eithun
Lynne Morgan
Michelle Jensen
Pat Cork
Paula Buege
Shelby McCulley
Teresa Steinmetz

Thanks to the OCMH Research Advisory Council



Andrea Gromoske
Angela Witt
Chris Keenan
Daniel Kiernan
Ellie Hartman
Joe Zeimentz
Joseph Tatar
Kate McCoy
Kelsey Hill
Lola Awoyinka
Michelle Robinson
Tim Connor

Thanks to the OCMH Annual Report Reviewers



Andrea Gromoske
Angela Rohan
Andrea Jacobson
Angela Witt
Brittany Grogan
Chris Keenan
Christine Niemuth
Daniel Kiernan
Ellie Hartman
Joe Zeimentz
Joseph Tatar
Julianne Dwyer
Justin Martin
Kate McCoy
Kelsey Hill
Kerry Zaleski
Lola Awoyinka
Melissa Heinz
Michelle Robinson
Molly Zemke
Tim Connor
Yonah Drazen

Appendix: Financial Tables of Child- and Family-Serving Agencies, 2017

Department of Children and Families (DCF) Financial Table

Funding Title	Purpose	Amount	Total Amount
Children and Family Aids (2016-2017)	Counties may use financial aids for services related to child abuse and neglect, fetal abuse (including prevention, investigation, and treatment), juvenile justice, and other target populations. Approximately 50% of the CFA is used for child abuse and neglect, 27% for other child welfare services to families ($17,948,385), and 23% for community-based juvenile justice corrections placements. Counties are required to match at 9.89%.[12]		**$68,327,900**
	General Purpose Revenue	$25,658,600	
	Title IV-E funding for a portion of the cost of services for children who meet financial eligibility criteria and are placed in out-of-home care. DCF distributes federal reimbursements to counties.[3]	$32,472,600	
	Title IV-B, Subpart 1 funding is primarily used to keep children with their families. These services include respite care, intensive family treatment, and individual and family counseling. Funds are distributed to states on the basis of their under-21 population and per capita income. States are required to provide a 25% funding match to the federal grant.[4]	$2,900,000	

[1] Austin, Sam and Gentry, John, *Community Aids/Children and Family Aids*, Informational Paper 47, Wisconsin Legislative Fiscal Bureau, January, 2015 p. 6
[2] Gentry, John, *Child Welfare Services in Wisconsin*, Informational Paper 49, Wisconsin Legislative Fiscal Bureau, January, 2017 p. 26
[3] IBID p. 27
[4] IBID p. 27

	Social Services Block Grant (SSBG) funding is used to address at least one of five goals: 1) prevent, reduce or eliminated economic dependency; 2) achieve or maintain self-sufficiency; 3) prevent or remedy neglect, abuse or exploitation of children and adults; 4) prevent or reduce inappropriate institutional care; and 5) secure admission or referral for institutional care when other forms of care are not appropriate. Up to 10% of the allotment can be transferred to preventative health and health services, behavioral health services, maternal and child health services, and low-income home energy assistance block grants. The funds may also be used for staff training, administration, planning, evaluation, and technical assistance to develop, implement, or administer Wisconsin's social service program.[5]	$4,006,900	
	Temporary Assistance for Needy Families Block Grant (TANF). The state may use up to 10% of this allocation for purposes consistent with the requirements of the SSBG.	$3,289,800	
Title IV-B, Subpart 2 (FFY2016)	Intended to promote safe and stable families through family preservation, family support, family reunification, adoption promotion, and support services. The federal Department of Health and Human Services distributes funds to states based on the share of children whose families receive supplemental nutrition assistance. The state must provide 25% match.[6]		**$5,052,200**
	State-level adoption, promotion and support	$957,000	
	Training and technical assistance to counties and tribes	$299,700	
	ACE Study and Trauma Project	$440,300	
	Family support, preservation and reunification	$3,355,200	
Program	**Description**	**Amount**	**Total Amount**

[5] IBID p. 27
[6] IBID p. 31

Family Foundations Home Visiting Programs (2016 - 17)	Services focused on improving birth outcomes, supporting maternal and child health, enhancing family functioning, promoting safety and development, and preventing child abuse and neglect.[7]		**$10,451,700**
	Empowering Families of Milwaukee Home Visiting Program: Services provided to pregnant and post-partum Milwaukee women in eleven zip codes that have high rates of poverty, child abuse and neglect referrals, and poor birth outcomes. TANF Funds[8]	$812,100	
	General Purpose Revenue	$985,700	
	Formula grant	$8,653,900	
	Competitive grant	$0	
Brighter Futures	Supports positive youth development and prevention programs in high-risk and high-poverty neighborhoods. Programs serve infants, children, youth and families and focus on high school graduation, vocational preparedness, improved social and other interpersonal skills, and responsible decision-making.[9]		**$4,021,200**
	General Purpose Revenue	$864,900	
	Substance Abuse Block Grant	$1,575,000	
	Temporary Assistance to Needy Families	$716,300	
	Title V Abstinence Education Grant	$865,000	

[7] IBID p. 44
[8] IBID p. 44
[9] IBID p. 45

SAFE Milwaukee (2017)	This is a short-term, behaviorally oriented family therapy program targeted to youth ages 10 to 18 that have severe behavior challenges, are frequently and/or at risk of being delinquent. United Neighborhood Centers of Milwaukee (UMOS) facilities are located in the neighborhoods with the youth at highest risk of delinquencies.[10]		$850,000
Post Reunification Services Waiver	Case managers develop a twelve month post-reunification plan based on the needs of the child and family. The plan may include trauma-informed services, crisis stabilization services, in-home therapy, alcohol and drug assessment and treatment for parents, mental health services, respite care, transportation, and connection to community services.[11] This is a five year waiver totaling $10,000,000 with $2,000,000 designated annually to provide flexible funding for reunifying families.		$2,000,000
Domestic Violence Services	Grants to local domestic violence service providers to assist victims of domestic violence. Services are provided to adults and children.		$5,983,900
Youth Aids Funding	Under Act 55, DCF is provides counties with an annual allocation of state and federal funds that may be used to pay for juvenile delinquency-related services, including out-of-home placements and non-residential, community-based services. Counties may supplement their expenditures with funding from other sources including community aids, other state aids to counties, county tax revenues, and special grant monies. The Department of Corrections retains oversight over direct juvenile justice services, such as juvenile correctional facilities, the serious juvenile offender program, and aftercare supervision.		**$90,767,300**
	General Purpose Revenue	$88,591,400	
	FED	$2,175,900	
Youth Community Intervention Program	Early intervention services for first-time juvenile offenders. Funding is distributed to eligible counties using a formula that calculates each county's allocation on the bases of juvenile arrests for violent crimes, juvenile arrest for serious property crimes and juvenile correctional placements.		$3,700,000

[10] IBID p. 45
[11] IBID p. 16

Youth Diversion Program			$954,000
Special Needs Adoption	Services provided include training to pre-adoptive homes, case management, and adoption studies[12] for children with special needs for whom it is difficult to find an adoptive home.		$4,167,800
Adoption Assistance	To be eligible, a child must have one of the following special needs: be 10 years or older, if age is the only factor in determining eligibility; a member of a sibling group of three or more youth; at risk of having or has five or more moderate to intense needs due to: adjustment to trauma, limitations in life functioning (including physical, mental and dental health), relationships with family members and social skills, functioning in a child care or school setting, behavioral and emotional needs or risk behaviors; or belonging to a minority race which limits the timely placement of a child due to a lack of appropriate placement options.[13]		**$91,081,00**
	General Purpose Revenue	$48,930,300	
	Title IV-E (FED)	$42,150,700	
Adoption Resource Centers	Provides information on the adoptive process to prospective adoptive parents, birth parents, adoptive families, professionals, and the general public.[14]		$676,000
Post Adoption Resource Centers	Seven agencies provide education, support and services to adoptive families; provide an understanding of issues facing adoptive families among human service providers, schools and medical care providers; and collaborate to address the needs of adoptive families. Title IV-B Sup part 2 each center receives between $92,500 – 110,000. Additionally under 2015 Act 55 $225,000 GPR annually supports the federal grants. [15]		$812,500

[12] IBID p. 19
[13] IBID p. 21
[14] IBID p. 21
[15] IBID p. 22

Kinship Care (2016-17 Budgeted)	Supports children who reside outside of the home with a relative rather than placing the child in foster care or other out-of-home placements. Federal TANF[16]		$21,435,000
Boys and Girls Clubs	Represents 25 distinct Boys and Girls Clubs with 42 program sites throughout the state. The objectives are to improve the social, academic and employment skills of low-income at risk youth. Skills Mastery and Resistance Training (SMART) curricula focuses on helping youth develop healthy attitudes and responsible behaviors that lead to abstinence from sexual involvement and substance abuse; positive relationships free of violence and abuse, and overall health. Families eligible for free and reduced lunch program may participate in a full range of services. TANF		$1,175,000
Child Abuse and Neglect Prevention Board (2016 - 17)	CANPB supports services to prevent child abuse and neglect through partnerships and investments. The Board administers the Children's Trust Fund (CTF) and is required to solicit and accept contributions, grants, gifts and bequests for CTF.[17]		**$3,041,200**
	General Purpose Revenue	$995,00	
	Title II of the Child Abuse Prevention and Treatment Act (CAPTA) Federal Funding (FED)	$632,700	
	Program Revenue comes from the sale of duplicate birth certificates, services such as state mailings, special computer services, training programs, printed materials and publications.	$1,398,500	
	Segregated Funding (SEG)	$15,000	
	Matching funds are also provided for the sexual abuse prevention campaign, the family resource center grants and the community-based family resource and support program grants.		

[16] Gentry, John D., Wisconsin Works (W-2) and Other Economic Support Programs, Informational Paper 43, Wisconsin Legislative Fiscal Bureau, January 2017, p. 45

[17] IBID p. 42

Child Advocacy Centers (CACs)	Provide comprehensive services to child victims and their families by coordinating services from law enforcement and criminal justice agencies, child protective services, victim advocacy agencies, and health care providers. The Department of Justice provides 14 annual grants to CACs in 14 counties.[18]		**$6,857,800**
	General Purpose Revenue	$2,388,100	
	Funding for the CAC grants is provided from Justice Information System Surcharge revenue. The $21.50 surcharge is assessed with a court fee for certain court procedures.	$3,645,800	
	FED	$823,900	
Child Care and Development Funds (CCDF)	The federal child care and development block grant provides a combination of discretionary and entitlement funds for child care services for low-income families and to improve the quality and supply of child care for all families.[19]		**$276,949,199**
	FY 2017 Federal CCDF (Discretionary, Mandatory and Matching)	$98,666,549	
	Federal TANF Transfer to CCDF	$61,833,144	
	Direct Federal TANF spending on Child Care	$100,000,000	
	State CCDF Maintenance of Effort Funds	$16,449,406	

[18] Steinschneider, Michael, *Crime Victim and Witness Services*, Informational Paper 59, Wisconsin Legislative Fiscal Bureau, January, 2017 P. 11

[19] Gentry, John D., Wisconsin Works (W-2) and Other Economic Support Programs, Informational Paper 43, Wisconsin Legislative Fiscal Bureau, January, 2017 p. 77

Child Care and Development Funds (2015) https://www.acf.hhs.gov/occ/resource/fy-2015-ccdf-table-4a

Department of Corrections (DOC) Financial Table

Funding Title	Purpose	Amount	Total Amount
Juvenile Justice System	Funding for the state costs of the juvenile justice system in 2016-17 (the $66.7 mill includes the 31,424,400 for the facilities)		**$66,700,000**
Secured Facilities	The Division of Juvenile Corrections (DJC) operates two juvenile correctional facilities -- one facility for males (Lincoln Hills) and one for females (Copper Lake).[20]		$31,424,400
	Mendota Juvenile Treatment: DHS operates a 29-bed, secured mental health unit for male juveniles who have complex mental health issues.[21]	$4,663,100	
	General Purpose Revenue $1,365,500		
	Program Revenue $2,997,600		
	Lincoln Hills School - average daily population (2016 – 17): 231	$21,710,100	
	Copper Lake School - average daily population (2016 – 17): 53	$4,466,800	
	Grow Academy - A male residential treatment program located in Dane County with an agricultural science-based curriculum and a capacity of 12. Average daily population for June – December of 2015: 5.[22]	$884,400	
Serious Juvenile Offenders	State funded. Average daily population (2016-17): 206		$14,900,000
Juvenile Corrective Sanctions Program	Provides intensive supervision in the community. DOC is required to provide a corrective sanctions program to serve an average of 136 juveniles in not less than three counties, including Milwaukee County. An average of not more than $3,000 annually is provided to purchase community-based treatment services for each corrective sanctions slot.[23]		$4,300,000

[20] Wynn, Sarah and Gentry, John., *Juvenile Justice and Youth Aids Program*, Informational Paper 55, Wisconsin Legislative Fiscal Bureau, January, 2017, p. 20.
[21] IBID, p. 20
[22] IBID, p. 20
[23] IBID, p. 27

Utility Aid	State tax revenues used with county discretion.[24]	$33,900,000
County and Municipal Aid	State tax revenues used with county discretion.[25]	$122,700,000
Grants Through the Department of Justice	Provided via the Juvenile Justice Delinquency Prevention Act. Approximately 75% of these formula grants are distributed to local governments for juvenile justice programs, including delinquency prevention, early intervention, and other services.	$639,300
Division of Juvenile Corrections (2016 – 17)	The state directly funds certain administrative costs.[26]	$2,400,000
Child Advocacy Centers	Comprehensive services for child victims and their families including coordination with law enforcement, criminal justice agencies, child protective services, victim advocacy agencies, and health care providers.[27]	$238,000

[24] IBID, p. 34
[25] IBID, p. 34
[26] IBID, p. 35
[27] Steinschneider, Michael, *Crime Victim and Witness Services*, Informational Paper 59, Wisconsin Legislative Fiscal Bureau, January, 2017, p.11.

Department of Health Services (DHS) Financial Table: 2017

Funding Title	Description	Amount	Total
Basic County Allocation (2015 - 16)	**Counties may use funding to support Family Support Programs as well as services to address issues such as mental health, developmental disabilities, alcohol and other drug abuse, and dementia.**[28]		**$169,731,700**
	General Purpose Revenue	$137,372,600	
	Social Services Block Grant (SSBG): Funding may be used to provide services directed toward at least one of five goals: 1) Prevent, reduce or eliminate economic dependency; 2) Achieve or maintain self-sufficiency; 3) Prevent or remedy neglect, abuse or exploitation of children and adults; 4) Prevent or reduce inappropriate institutional care; and 5) Secure admission or referral for institutional care when other forms of care are not appropriate. Up to 10% of the allotment can be transferred to preventative health and health services, alcohol and drug abuse services, mental health services, maternal and child health services, and low-income home energy assistance block grants. The funds may also be used for staff training, administration, planning, evaluation, and technical assistance to develop, implement, or administer the state's social service programs.[29]	$21,104,500	
	Temporary Assistance for Needy Families Block Grant (TANF): The state may use up to 10% of this allocation for purposes consistent with the requirements of the SSBG. [30]	$11,254,600	

[28] Austin, Sam, and Gentry, John, *Community Aids/Children and Family Aids*, Informational Paper 46, Wisconsin Legislative Fiscal Bureau, January, 2017 p. 3.
[29] IBID, p.3
[30] IBID, p. 3

Substance Abuse Block Grant (SABG)	Supports the development and implementation of substance abuse prevention, treatment, and rehabilitation. States must spend at least 20% of on education and prevention activities and at least 10% on substance abuse treatment services for pregnant women and women with dependent children.[31]			**$27,005,484**
	Community Aids Allocation (20% Prevention)		$9,735,700	
	Women's Substance Abuse Treatment Initiatives[32]		$3,558,200	
	Treatment Related Grants		$3,423,000	
	WI Department of Children and Families		$3,158,000	
	Brighter Futures (Prevention)	$1,575,000		
	Bureau of Milwaukee Child Welfare (20% Prevention)	$1,583,000		
	WI Department of Health Services, State Operations/Administration		$2,219,600	
	WI Department of Corrections		$1,347,400	
	Division of Juvenile Corrections	$235,700		
	Female Halfway House	$352,200		
	Division of Community Corrections	$406,300		
	Native American Halfway House	$152,400		
	Division of Adult Institutions - Taycheedah	$202,600		
	Juvenile Justice Treatment Grants		$1,621,600	
	Other primary prevention initiatives		$2,134,500	

[31] IBID, p. 3
[32] Community Mental Health and Substance Abuse Prevention and Treatment Block Grant reporting from DHS-DMHSAS

Mental Health Block Grant (FFY 2016 - 17)	Funding supports comprehensive community mental health services (evaluation, planning, administration, and educational activities related to these services) to adults and children. Services include respite care, adult family home care, community prevention services, crisis intervention, counseling, and therapy. States may not use these funds to provide in-patient services or to make cash payments to recipients of health services. State may use up to 5% to support administrative costs.[33]		**$8,267,100**
	Community Aids Allocation: Funds support a wide range of human services.	$2,513,400	
	Recovery, Early Intervention and Prevention supports evidence-based early intervention services for people suffering from first-episode psychosis, as well as suicide prevention efforts with a focus on reducing disparities among culture subgroups and veterans.	$1,232,000	
	Children's Initiatives: Funds provide a portion of the funding for coordinated services teams.	$1,826,500	
	Consumer and Family Support: Funds are distributed through grants for mental health consumer and family supports.	$1,127,300	
	NAMI $240,900		
	Wisconsin Family Ties $265,900		
	Independent Living Resources $209,000		
	Peer-run organizations $297,148		
	Access to Independence $114,352		
	State Operations	$710,000	
	Transformation Activities: Funding for a wide range of activities with a focus on increasing access to services and developing evidence-based practices.	$546,800	

[33] Dyck, Jon, *Services for Persons with Mental Illness*, Informational Paper 48, Wisconsin Legislative Fiscal Bureau, January 2017, p. 9-11.

	Recovery, Early Intervention, and Prevention: Funding used for self-directed care, the Child Psychiatric Consultation Program, and the promotion of tribal best practices for treatment of co-occurring disorders.	$1,232,000	
	Training and Technical Assistance: training of mental health professionals.	$181,800	
	Protection and Advocacy: Funding goes to Disability Rights Wisconsin.	$75,000	
	System Change Grants: Funding supports the initial phase of mental health recovery-oriented system changes, prevention and early intervention strategies, and meaningful consumer and family involvement.	$54,300	
Community Mental Health Allocation	Allocates funds to counties specifically for mental health services. This fund is a consolidation of five existing mental health grant programs into a single program. Counties must spend the funds received on community-based services for adults or children with a mental diagnosis or be at risk for a serious mental illness or serious emotional disorder.		**$24,348,700**
Coordinated Services Teams (CST)	Designed for children who are involved in multiple systems of care (e.g., mental health, substance abuse, child welfare, juvenile justice, special education, or developmental disabilities). Additionally, DHS supports county and tribal CST Initiatives for children who satisfy the following:[34] have a severe emotional disorder; are at-risk of placement outside the home; are in an institution and are not receiving coordinated, community-based services; or are in an institution, but would be able to return to community placement or their homes if services were provided.		**$4,600,000**
	General Purpose Revenue	$2,600,000	
	Mental Health Block Grant	$ 1,200,000	
	Medical Assistance Hospital Diversion Funds	$700,000	
	Department of Children and Families	$100,000	

[34] IBID p. 11-12

Opioid Treatment Centers	The Department is required to provide two to three programs in rural, underserved areas. These programs may provide medically-assisted treatment (although not using methadone), residential services, counseling, or abstinence-based treatment.		**$2,000,000**
Comprehensive Community Services (CCS)	A county or regionally- based program for adults and children with mental health issues. Most services are provided in home and/or in the community as opposed to a clinician's office. CCS is considered a psychosocial rehabilitation service and is reimbursable via Medicaid.[35]		**$16,701,900**
	General Purpose Revenue	$10,202,000	
	Federal	$6,499,900	
Child Psychiatry Consultation Program	Provides consultation and education to primary care clinicians on children's mental health needs; serves children and youth in Milwaukee County and in 15 counties in northern Wisconsin, including Ashland, Bayfield, Florence, Forest, Iron, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Sawyer, Taylor, Vilas, and Wood.[36]		**$2,000,000**
	General Purpose Revenue	$500,000	
	Kubly Foundation	$1,500,000	
State Mental Health Institutes	DHS Operates the Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute near Oshkosh. These facilities provide psychiatric services to adults, adolescents, and children who are either civilly-committed or are forensic patients committed as a result of a criminal proceeding. Mendota operates two units at the Mendota Juvenile Treatment Center that have the capacity to serve 29 adolescent males from Wisconsin's juvenile correctional facility that's behavioral and treatment needs exceed the resources available at that facility.[37]		**$137,300,000**
	Mendota Mental Health (total budget)	$78.7 million	
	Winnebago (total budget)	$58.6 million	

[35] IBID, p. 6
[36] IBID, p. 12
[37] IBID, p. 26

Children's Community Options Program (CCOP)	As part of 2015 Act 55, and effective January 1, 2016, the Family Support Program funding was merged with the portion of COP funding allocated to children to form CCOP. CCOP provides supports and services to children living at home or in the community who have one or more of the following long-term disabilities: developmental disabilities, physical disabilities or severe emotional disturbance.[38]		**$9,025,900**
Birth to 3 Program (2015)	Serves children under 3 years of age who have developmental delays and disabilities.[39]		**$40,847,205**
	Federal Part C Allocation	$5,923,328	
	State GPR	$5,709,654	
	Medicaid (estimated)	$9,059,296	
	Community Aids	$4,460,645	
	Parental Cost Share	$491,447	
	Private Insurance	$2,773,801	
	Other	$612,806	
Title V	Regional Centers for Children and Youth with Special Health Care Needs[40]		**$1,218,526**

[38] Bentzen, Alexandra, *Services for Persons with Developmental Disabilities*, Information Paper 47, Wisconsin Legislative Fiscal Bureau, January 2017, p. 13
[39] IBID, p. 14
[40] https://www.dhs.wisconsin.gov/mch/blockgrant/budget-narrative.pdf

Department of Public Instruction (DPI) Financial Table

Funding Title	Purpose	Amount
Grants to Local Educational Agencies (LEAs) – Elementary and Secondary Education Act (ESEA) - Title I (2016)	Supplements state and local funding for low-achieving children, especially in high-poverty schools. The program finances the additional support and learning opportunities often required to help disadvantaged students progress along with their classmates.[41]	$216,376,319
School Improvement Programs – Title I	Four percent of the Title I allocation is reserved for school improvement activities.	$6,400,350
State Agency Program-Migrant – Title I	Title I migrant education is a federally-funded program that assists selected local school districts in providing supplemental education services needed by migratory children.[42]	$627,345
State Agency Program - Neglected	Federally Neglected and Delinquent funds are provided to assist at-risk, neglected, delinquent, and incarcerated youth so that they may have the same opportunities as students in other Title I institutional programs.[43]	$814,785
Homeless Children and Youth Education	Implements the McKinney-Vento Homeless Education Assistance Act to assure homeless children and unaccompanied youth have access to public schools programs.[44]	$1,0006,643
Special Education	Special education is provided by school districts, either independently or through cooperative arrangements with other districts, cooperative educational service agencies (CESAs), and County Children with Disabilities Education Boards (CCDEBs). The state reimburses a portion of the costs for educating and transporting pupils enrolled in special education, including school age parent programs.[45]	$368,939,100

[41] https://www2.ed.gov/about/overview/budget/statetables/18stbystate.pdf (2017)
[42] Dpi.wi.gov/migrant
[43] Dpi.wi.gov/neglected-delinquent
[44] Dpi.wi.gov/homeless
[45] Kava, Russ and Pugh, Christa, *State Aid to School Districts*, Informational Paper 24, Wisconsin Legislative Fiscal Bureau, January 2017, p. 21

High-Cost Special Education Aid	Additional aid can be provided if the applicant incurred, in the previous school year, more than $30,000 of non-administrative costs for providing special education and related services to a child, assuming those costs were not eligible for reimbursement under the state Special Education and School-age Parent Program, the federal Individuals with Disabilities Education Act, or the federal Medicaid program.[46]	$8,500,00
Supplemental Special Education Aid	Aid to school districts meeting the following criteria in the prior year: 1) per pupil revenue limit authority below the statewide average; 2) special education expenditures as a percentage of total district expenditures above 16%; and 3) membership is less than 2,000 pupils. A district may receive either supplemental special education aid or high costs special education aid in a given year, but not both.[47]	$1,750,000
Per Pupil Aid	A sum sufficient per pupil aid appropriation was established in 2013 Act 20. Each school district received a $75 per pupil aid payment in 2013 - 14 and a $150 per pupil payment in 2014 - 15 and each year thereafter.[48]	$210,992,800
Student Achievement Guarantee in Education (SAGE)	The SAGE program awards five-year grants to school districts where at least 50% of at least one school's population is made up of low-income pupils. School districts must do the following in each SAGE school: 1) Reduce each class size to 18 pupils for every one teacher, or 30 pupils to two teachers in the applicable grades; 2) Keep the school open every day for extended hours and collaborate with community organizations to make educational and recreational opportunities as well as community and social services available in the school to all district residents; 3) Provide a rigorous academic curriculum designed to improve academic achievement; and 4) Create staff development and accountability programs that provide training for new staff members, encourage employee collaboration, and require professional development plans and performance evaluations. 425 schools in 305 districts participated with approximately $2,027 paid per eligible student (2013 - 2014).[49]	$109,184,500

[46] IBID, p.21
[47] IBID, p. 21
[48] IBID, p. 22
[49] IBID, p. 23

SAGE Debt Service	If a school board, other than Milwaukee Public Schools, passed a referendum and has received DPI approval prior to June 30, 2001, it is eligible for state aid equal to 20% of debt service costs associated with SAGE building costs. Eleven school districts participated in 2014 - 15.[50]	$133,700
Pupil Transportation	School districts required by state law to furnish transportation services to public and private school pupils enrolled in regular education programs, including summer school, are eligible to receive categorical aid.[51]	$23,954,000
High-Cost Transportation Aid	A district is eligible for aid if per pupil transportation costs (based on audited information from the previous fiscal year) exceed 150% of the statewide average per pupil cost.[52]	$7,500,000
Sparsity Aid	Created for school districts meeting the following criteria: 1) School district membership in the prior year of less than 725 pupils; 2) Population density of less than ten pupils per square mile of the district's area; and 3) At least 20% of school district membership qualifies for free or reduced-priced lunch. 133 districts participated in 2014 - 15.[53]	$17,674,000
Bilingual-Bicultural Aid	School districts are required to provide special classes to students of limited-English proficiency if ten or more LEP pupils are in a language group in grades K - 3, or 20 or more in grades 4 - 8 or 9 - 12. Fifty-two school districts participated in 2013 - 14.[54]	$8,589,800
Tuition Payments	The state reimburses the cost of educating children who live where there is no parental property tax base support.[55]	$8,242,900
Head Start Supplement	Provide a supplement to the federal Head Start Program. Federal funding in Wisconsin was an estimated $118.9 million in federal fiscal year 2014 -15. Forty-one grantees including five school districts and three CESAs.[56]	$6,264,100

[50] IBID, p. 23
[51] IBID, p. 24
[52] IBID, p. 25
[53] IBID, p. 25
[54] IBID, p. 26
[55] IBID, p. 27

Educator Effectiveness Grants	Provide reimbursements to participating schools districts for expenses associated with system development, training, software, support, resources, and ongoing refinement, or for those districts using an approved alternative evaluation process, to fund development and implementation of the equivalent process. Districts receive a payment of $80 for each teacher, principal, or other licensed educator.[57]	$5,746,000
School Lunch	The state makes payments to school districts and private schools for the following: 1) to partially match the federal contribution under the national school lunch program that provides free or reduced price meals to low-income children; 2) to support the cost of reduced price meals served to the elderly; 3) to reimburse the cost of milk provided to low-income children in preschool through fifth grade in schools not participating in the federal special milk program; and 4) to provide a per meal reimbursement for school breakfast programs.[58]	$4,218,100
County Children with Disabilities Boards	Fiscally independent CCDEBs receive state aid if they fund the local share of their educational programs through the county property tax levy.[59]	$4,067,300
School Breakfast	Funding is used to provide a per meal reimbursement of $0.15 for each breakfast served under the federal School Breakfast Program.[60]	$2,510,500
Peer Review and Mentoring	CESAs may apply to DPI for a grant to provide technical assistance, training, peer review, and mentoring for teachers who are licensed by or have been issued a professional teaching permit by the State Superintendent. 20% matching funds or in-kind services are required.[61]	$1,606,700
Four-Year-Old Kindergarten	Two year grants to implement new four-year-old kindergarten programs. Eight school districts participated in 2013 - 14.[62]	$1,350,000

[56] IBID, p. 27
[57] IBID, p. 28
[58] IBID, p. 28
[59] IBID, p. 22
[60] IBID, p. 28
[61] IBID, p. 29
[62] IBID, p. 29

School Day Milk	School districts may be reimbursed for the cost of milk provided to low-income children in preschool through fifth grade in schools that do not participate in the federal special milk program.	$617,100
Aid for Transportation – Open Enrollment	A child with disabilities requiring transportation under his or her individual education plan and aid for families who cannot afford the cost of transportation for pupils enrolled in classes at other educational institutions.[63]	$434,200
Aid for Cooperative Educational Service Agencies	Aid is provided for the administrative cost of each of the 12 CESAs. School districts match.[64]	$237,200
Gifted and Talented	Aid is provided annually as a grant program to provide gifted and talented pupils with services and activities not ordinarily provided in a regular school program.[65]	$237,200
Supplemental Aid	Schools meeting criteria can apply to DPI for equalization aid. One school district participated in 2014 - 15.[66]	$100,000
Aid for Transportation – Youth Options	Allows any 11th or 12th grade public school student to enroll in courses at a postsecondary institution for high school or postsecondary credit...[67]	$17,400
Science, Technology, Engineering and Math (STEM) grants	Grant funding for districts engaging in innovative science, technology, engineering, and mathematical education projects. 25% matching funds are required.[68]	$250,000
Alcohol and Other Drug Abuse (AODA) – Program Revenue Funded	Provides block grants to address the problem of alcohol and other drug abuse among school-aged children. Program revenue from the penalty assessment surcharge funds these grants. 52 school districts and 4 CESAs in 2013 - 14.[69]	$1,284,700

[63] IBID, P. 32
[64] IBID, p. 29
[65] IBID, p. 31
[66] IBID, p. 31
[67] IBID, p. 32
[68] IBID, p. 30
[69] IBID, p. 29

Tribal Family Services' Financial Table

Program	Description	Amount	Total Amount
Family Services Program (FSP)	Jointly administered by Department of Health Services and the Department of Children and Families. Tribes may use funds from both departments to support tribal staff that provides integrated services to families.[70]		**$2,027,000**
	General Purpose Revenue	$1,271,900	
	Title IV-B sub-part 2	$408,700	
	Federal Community Services Block Grant Funding can be used for domestic abuse, child welfare, self-sufficiency, teen parenting, and childcare. Other funding must be used for: 1) Adolescent pregnancy prevention and parenting skills; 2) child respite care; 3) permanency for children in out-of-home care; 4) family preservation and support services; 5) empowerment for low-income individuals, families and communities to overcome the effects of poverty; 6) domestic abuse intervention, prevention, and education; 7) improve family functioning.	$346,400	
DPI Allocation	Tribal Language Revitalization Grants - PR Funded These grants are funded from tribal gaming program revenue transferred from DOA[71]		**$222,800**
Child Care and Development Funds	The federal child care and development block grant provides a combination of discretionary and entitlement funds for child care services for low-income families and to improve the quality and supply of child care for all families.		**$1,800,000**

[70] Gentry, John and Whitaker, Aaron, *Community Aids/Children and Family Aids*, Wisconsin Legislative Fiscal Bureau, January 2017, p. 8
[71] Kava, Russ and Pugh, Christa, *State Aid to School Districts*, Informational Paper 24, Wisconsin Legislative Fiscal Bureau, January 2017, p. 31.

Discretionary Grants Financial Table

Grantor/ Award	City	Program Period	Description	Amount
SAMHSA Grant Awards[72]				
Wisconsin Department of Children and Families	Madison	10/17 – 9/22	Increase availability, accessibility and coordination of trauma-specific treatment on Milwaukee and Racine Counties for families in the child welfare system or at risk of entering the system.	$1,800,000
Wisconsin Department of Health Services	Madison		Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation; combination of infrastructure and direct treatment to improve treatment for adolescents (12 -18) and/or transitional aged youth (16 – 25) with substance use disorders (SUD) and mental health challenges.	$1,800,000
Milwaukee Health Department	Milwaukee	10/16 – 9/21	Assist high-risk youth and their families and promote resilience and equity in communities.	1,000,000/yr.
Dryhootch	Milwaukee	09/14 – 09/17	Provide peer support to veterans and their families.	$100,000/yr.
Appleton School District	Appleton	09/14 - 09/16	Certify 30 Youth Mental Health First Aid instructors; train 1,200 adults.	$100,000/yr.
Lac Du Flambeau Band of Chippewa	Lac du Flambeau	09/14 -09/17	Expand substance abuse treatment capacity in Tribal Healing to Wellness Courts and Juvenile Drug Courts.	$290,078
Neenah Joint School District	Neenah	09/14 – 09/16	Focus on 12-18 year olds using adults trained in Youth Mental Health First Aid.	$100,000/yr.
United Community Center, Inc	Milwaukee	09/14 – 09/17	Provide trauma-informed, gender-responsive, culturally competent services within a family-centered treatment model for 126 Milwaukee County pregnant and post-partum women (primarily Hispanic) with substance uses disorders. Partnership with Sixteenth Street Community Health Center.	$524,000/yr.

[72] www.samhsa.gov/grants-awards-by-state/details/Wisconsin

Milwaukee Public Schools	Milwaukee	09/14 - 09/16	Train 410 residents of the city of Milwaukee in Youth Mental Health First Aid including staff from Milwaukee Public Schools, Milwaukee Police Dept., Rogers Behavioral Health System, Boys and Girls Club, United Neighborhood Centers increasing the capacity of the community to detect and respond to mental health issues among school-aged youth.	$100,000/yr.
Fond du Lac School District	Fond du Lac	09/14 - 09/16	Certify 8 trainers in Youth Mental Health First Aid; build on existing Mental Health Services Steering Committee.	$100,000/yr.
Wisconsin Family Ties	Madison	09/15 – 09/16	Develop statewide peer network for recovery and resiliency	$100,000/yr.
Wisconsin Family Ties	Madison	07/13 0 06/16	Enhance the capacity and capability of families to drive the transformation of the children's mental health system of Wisconsin.	$70,000/yr.
County of Barron	Barron	09/09 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.
Red Cliff Band of Lake Superior Chippewa	Bayfield	09/14 - 09/17	Provide system of care Maamawi (Together) Red Cliff Circles of Care Program.	$399,998/yr.
Edgerton Hospital and Health Services	Edgerton	09/09 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.
Northeastern WI Area Health Ed Center	Manitowoc	09/14 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.
Menominee of WI Indian Tribal Council	Keshena	09/14 - 09/19	Prevent youth suicide.	$195,859/yr.
Marshfield Clinic Research Foundation	Marshfield	09/14 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.
Winnebago Co Health Dept.	Oshkosh	09/14 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.

University of WI Eau Claire	Eau Claire	09/14 -09/17	Prevent suicide (Hope Inspires); provide info on mental health promotion and suicide prevention resources, class and speakers.	$101,185/yr.
City of Janesville	Janesville	09/15 – 09/18	Train 1.6% of the adult population in Mental Health First Aid.	$125,000/yr.
Wisconsin Dept. of Health Services – Project YES!	Madison	09/14 – 09/19	Target youth and young adults aged 16 – 25 who are at risk for, or experiencing mental health problems in Jefferson and Outagamie Counties.	$1,037,360/yr.
Wisconsin Dept. of Public Instruction – Project Aware	Madison	09/14-09/19	1) Make schools safer; 2) Improve school climates;3) Increase capacity to identify warning signs of mental health problems among children and make appropriate referrals to mental health care; and 4) Increase capacity of the state and local education agencies to connect children and youth with behavioral health issues with needed services.	$1,950,000/yr.
Wisconsin Dept. of Public Instruction – Safe Schools/Healthy Students	Madison	09/13 – 09/17	Create infrastructure to improve social and emotional skills, enhance a positive sense of self, increase family, school and community connections, address behavioral and mental health needs, and create a safe and violence free school environment.	$2,214,000/yr.
West Allis - Milwaukee	West Allis	09/09 – 09/19	Prevent and reduce youth substance use.	$125,000/yr.
Berlin Area School District	Berlin	09/14 - 09/16	Certify 8 Youth Mental Health First Aid trainers; train 250 adults to recognize the signs and symptoms of mental health problems; connect children with services.	$100,000/yr.
School Dist of McFarland	McFarland	09/14 - 09/16	Provide Mental Health First Aid and Youth Mental Health First Aid in 6 local educational agencies; train 8 additional trainers for a total of 16; use a communities-train-communities approach.	$95,256/yr.
Arbor Place, Inc.	Menominee	09/15 – 09/18	Train 400 adults on Mental Health First Aid.	$125,000/yr.
Outreach Community Health Centers	Milwaukee	09/15 – 09/18	Train 30 instructors to provide Mental Health First Aid training to at least 5,625 other adults who engage with transition-aged youth.	$116,587/yr.

Wauwatosa School District	Wauwatosa	09/15 – 09/18	Certify 12 trainers in Youth Mental Health First Aid and conduct 18 workshops over three years training a minimum of 360 adults who regularly interact with youth in the community.	$125,000/yr.
Assistant Secretary for Planning and Evaluation Poverty Research Center	Madison	09/11 -9/16	Continued research and evaluation of important social policy issues associated with the nature, causes, correlates and effects of income dynamics, poverty, individual and family functioning, and child well-being.	$1,299,680/yr.
Campus Suicide	Madison	08/12 -07/15	Implement campus/community Suicide Prevention Partnership Council; implement evidence-based practices to reach out to high risk populations.	$102,000/yr.
Statewide Family Network Grants	Madison	07/13 - 06/16	Transform children's mental health system; children to 18 and young adults to age 26.	$70,000/yr.
DHHS Office of Adolescent Health				
Pregnancy Assistance Fund *State of Wisconsin - DPI*	Madison	2013 - 2016	Improve education, economic, health, and social outcomes for school-aged parents and their children. Ten grants to school districts with 25 targeted high schools.	$1,500,000/yr.
ACF Office of Family Assistance[73]				
Healthy Marriage and Responsible Fatherhood Grants/ New Pathways for Fathers and Families	Milwaukee	10/15 – 9/20	Encourage fathers to be present in their children's lives.	$2,000,000
ACF Grant Awards[74]				

[73] https://www.acf.hhs.gov/sites/default/files/ofa/hmrf_2015_grant_awards.pdf
[74] http://www.acf.hhs.gov/programs/ecd/early-learning/ehs-cc-partnerships/grant-awardees

Early Head Start-Child Care Partnerships *Indianhead Community Action Agency*	Ladysmith		Enhance and support early learning settings; provide new, full-day comprehensive services that meet the needs of working families and prepare children for the transition into preschool.	$1,400,000
Early Head Start-Child Care Partnerships *Dane Cty Parent Council, Inc.*	Madison		Enhance and support early learning settings; provide new, full-day comprehensive services that meet the needs of working families and prepare children for the transition into preschool.	$1,000,000
Early Head Start-Child Care Partnerships *Acelero, Inc.*	Milwaukee		Enhance and support early learning settings; provide new, full-day comprehensive services that meet the needs of working families and prepare children for the transition into preschool.	$1,200,000
Early Head Start-Child Care Partnerships *Next Door Foundation*	Milwaukee		Enhance and support early learning settings; provide new, full-day comprehensive services that meet the needs of working families and prepare children for the transition into preschool.	$4,800,000
Native Languages – Preservation and Maintenance *Red Cliff Band of Lake Superior*	Bayfield	2014-2017	Add Ojibwe language immersion to the Red Cliff Early Childhood Center's Head Start program and into the Kindergarten classroom at the Bayfield School to provide a foundation for language preservation and revitalization for current and future families within the Red Cliff community.	$272,057/yr.
State Personal Responsibility Education Program (PREP)	Madison	2015	Educate young people on abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS.	$932,700
Title V State Abstinence Grant	Madison	2015	Educate youth on abstinence; provide mentoring and counseling targeting youth in the foster care system and who are homeless.	$711,597

HRSA Maternal Child Health[75]				
Early Childhood Comprehensive Systems Grant	Madison	08/13 – 7/16	Connect early childhood systems and concurrent trauma and toxic stress initiatives to enhance skills of all early childhood system providers who touch the lives of very young children and their families; support evidence-based trauma interventions in 3 pilot communities.	$140,000/yr.
Eliminating Disparities in Perinatal Health *Great Lakes Inter-Tribal Council, Inc.*	Lac du Flambeau	07/01 – 3/19	Address infant mortality rates of Wisconsin Native Americans by increasing access to care through collaboration with tribal and non-tribal health care systems.	$750,000/yr.
Wisconsin Pediatric Medical Home	Madison	09/14 – 08/17	Provide children and youth with special health care needs with integrated care through family centered medical homes.	$300,000/yr.
Wisconsin Maternal Child Health Lead Program	Madison	07/1989 – 6/2016	Provide education in leadership, clinical practice, research, public health systems and policy to interdisciplinary MCH trainees.	$803,569/yr.
Department of Education[76]				
Bringing Evidence Based Practices to Practitioners in Wisconsin	Madison	10/15 – 09/19	Identify proven practices teachers can use to narrow gaps in student opportunity and achievement levels across all racial and ethnic backgrounds, and family income levels.	$5,242,866
Race to the Top Early Learning Challenge	Madison	1/13 – 12/16	Focus on improving young children's early learning and programming.	$34,052,084

[75] https://mchdata.hrsa.gov/dgisreports/Abstract/AbstractSummary.aspx?tbKeyword=Wisconsin&rbKeyword=Exact&SearchKeywordsOnly=Search
[76] http://findit.ed.gov/search?utf8=%E2%9C%93&affiliate=ed.gov&query=Wisconsin

School Climate Transformation Grants *Berlin Area Schools*	Berlin	2014 - 2018	Connect children, youth and families to appropriate services and supports; improve conditions for learning and behavioral outcomes for school-aged youths; and increase awareness of and the ability to respond to mental health issues among school-aged youths.[77]	$231,489
School Climate Transformation Grants *Appleton Area Schools*	Appleton	2014 - 2018	Connect children, youth and families to appropriate services and supports; improve conditions for learning and behavioral outcomes for school-aged youths; and increase awareness of and the ability to respond to mental health issues among school-aged youths.	$660,354/yr.
School Climate Transformation Grants *Wausau School District*	Wausau	2014 - 2018	Connect children, youth and families to appropriate services and supports; improve conditions for learning and behavioral outcomes for school-aged youths; and increase awareness of and the ability to respond to mental health issues among school-aged youths.	$747,030/yr.
School Climate Transformation Grants *State of Wisconsin - DPI*	Madison	2014 - 2018	Support Positive Behavioral Intervention and Supports, develop a school-based mental health training, and enhance supports for social and emotional development in 50 school-community teams selected over two years.[78]	$578,521/yr.
Project Prevent Grants	Milwaukee	2014 - 2018	Implement the Resilient Kids' program to build capacity in both knowledge and resilience in children, families, community and staff that will lead to decreased violence.[79]	$459,586/yr.

[77] http://www.ed.gov/news/press-releases/us-department-education-invests-more-70-million-improve-school-climate-and-keep-students-safe
[78] IBID
[79] http://www2.ed.gov/programs/projectprevent/2014awards.html

School Emergency Management Grants *State of Wisconsin – DPI*	Madison	2014 – 2015	Expand the capacity to assist school districts in developing and implementing high-quality school emergency operations plans.[80]	$472,509
National Institute of Justice[81]				
Wisconsin School Violence and Bullying Prevention Study *State of Wisconsin - DPI*	Madison	2015 - 2018	Examine the impact of Positive Behavioral Interventions and Supports in combination with a comprehensive bullying prevention program in middle schools.	$858,187
Medical College of Wisconsin[82]				

[80] http://www.ed.gov/news/press-releases/us-department-education-invests-more-70-million-improve-school-climate-and-keep-students-safe
[81] http://www.nij.gov/funding/awards/Pages/2015.aspx
[82] http://www.mcw.edu/Advancing-Healthier-WI-Endowment/Funded-Awards/HWPP-Funded-Awards/2017-Funded-Partnership-Awards.htm

Born Learning	Stevens Point	January 1, 2017 – June 30, 2019	Create a change in institutional policy and protocols within each targeted program that will result in a county-wide Social Service Triage System, providing coordinated screening, referrals, and intervention for at-risk families of children prenatally to age five. The five partners will engage with the community in key activities to successfully implement and disseminate the proposed change through forums, surveys/interviews, meetings, social media, print publications, and radio programs. Collective alignment with required partner reporting is reflected in the system change, creating collaborative referral processes, sustainable training, and collection and analysis of data to measure impact.	$350,000
Unscrambling Data for Urban and Rural Opioid Resiliency	Milwaukee/Sauk County/Wood County	January 1, 2017 – December 31, 2018	Automated, consistent data integration, analysis, interpretation of DOJ, OEM, and MEO information to develop and implement thoughtful, measurable policy to reduce opioid overdoses. This change strategy encompasses all steps in the public health model.	$298,754
Transforming Primary Prevention Systems to Build Family Protective Factors *Kenosha Co - CANPB*	Kenosha	July 1, 2017 – June 30, 2019	Prevent or mitigate the impact of toxic stress on families by embedding the Protective Factors Framework within policies and practices throughout Kenosha County's voluntary prevention programs offered to meet a wide variety of needs including family support, parenting skills development, household management, children's special healthcare needs, substance abuse services, mental health services and homelessness stabilization.	$298,600

Gathering Resources and Aligning Community Engagement (GRACE) Hub	La Crosse	July 1, 2017 – June 30, 2019	Meet the identified social determinants of health by creating a system to connect individuals and families to available resources. "Quick-Start Guide" developed by Community Care Coordination Learning Network/Pathways Community HUB Institute helps identify at-risk populations, address risk factors with evidence-based pathways and tie payment to positive outcomes.	$294,901
Health Equity Alliance of Rock County (HEAR)	Janesville	March – September 2017	Develop a storytelling report through the HEAR Community Engagement Project to ensure that community voices are reflected in future health needs assessments, priority setting processes, and programming to address the health needs of all Rock County residents.	$ 10,000
Well Washington Think Well and INVEST Coalition	West Bend	March – August 2017	Conduct a gap analysis to determine existing mental health service gaps in Washington and Ozaukee Counties to inform the development and implemental of a mental health friendly communities model.	$ 10,000
Rogers InHealth/WISE and Wisconsin Safe & Healthy Schools (WISH) Center	Milwaukee	March 2017 – February 2018	Develop a community/school collaboration model for implementation and expansion of the Honest, Open, Proud (HOP) program statewide to empower Wisconsin youth to make strategic decisions on whether and how to disclose mental health challenges.	$49,181

Network Evaluation	Madison	June 2017 – June 2018	Share existing tools for evaluating health improvement collaboratives and work together to adapt the tools for the mentee partners and develop a toolkit to share with other partnerships for evaluating collaboratives and networks as a key mechanism to health promotion and improvement efforts.	$50,000
Fond du Lac Area YScreen Program/ Beaver Dam Unified School District	Fond du Lac	July 2017- June 2018	Collaborate to improve the overall emotional health of youth by adapting Fond du Lac's process for developing and implementing the YScreen Program to build capacity to implement universal screening practices, expand referral networks and develop the ability to evaluate outcomes in Beaver Dam and Dodge County.	$50,000
Better Together	La Crosse County	July 1, 2017 – June 30, 2022	The La Crosse Mental Health Consortium facilitates several collaborative projects to improve the health of the population in the area.	$1,000,000
Building a Behavioral Health System to Reduce Reported Depression Among 6th – 12th Grade Students Marathon County Health Department	Marathon County	July 1, 2017 – June 30, 2022	Reduce reported depression in 6th-12th grade students in Marathon County by 5%.	$999,139

Creating Mental Wellness through Systems Change American Foundation of Counseling Services, Inc.	Brown, Kewanee, Door, Oconto and Shawno Counties	July 1, 2017 – June 30, 2022	Three community-wide collective impact initiatives will address the root causes of poverty.	$999,960
Healthier Community Action Team Behavioral Health Project Lac du Flambeau Public School, Indian Reservation	Lac du Flambeau Reservation; Vilas County	July 1, 2017 – June 30, 2022	Decrease excessive drinking by 10% among adults, age 18 -44.	$1,000,000
Improving Children's Mental Health Through School and Community Partnership	Racine County	July 1, 2017 – June 30, 2022	Enhance the social and emotional development of 3rd – 5th grade elementary school students in Racine Unified School District on the Panorama Social Emotional Learning student survey in the areas of emotional regulation and social awareness.	$$995,646
Mental Health Matters: Promoting Resilience for Chippewa Valley Youth Eau Claire City-County Health Department	Chippewa and Eau Claire Counties	July 1, 2017 – June 30, 2022	Reduce by 15% the number of middle and high school age youth who are at risk for depression.	$1,000,000

Milwaukee School, Home, and Community Collaboration to Improve Youth Mental Health Mental Health America	Milwaukee County	July 1, 2017 – June 30, 2022	Reduce the office discipline referral rate in Milwaukee Public Schools for children in Pre-Kindergarten through 6th grade by 25%.	$999,839
Healthy Teen Minds Winnebago County Health Department	Winnebago, Outagamie, and Calumet Counties	July 1, 2017 – June 30, 2022	Reduce by 20% the number of students in grades 7 – 12 who are at risk for or who are experiencing depression.	$1,000,000
Southwestern Wisconsin Behavioral Health Partnership Southwestern Wisconsin Community Action Program	Grant, Green, Iowa, Lafayette and Richland Counties	July 1, 2017 – June 30, 2022	Reduce the rate of people experiencing 14+ days of poor mental health by 10%.	$1,000,000
Enhancing Behavioral Health in Northern Wisconsin through Innovative Collaboration and Outreach Northlakes Community Clinic	Ashland, Bayfield, Iron, Douglas, Sawyer, and Washburn Counties	July 1, 2017 – June 30, 2022	Reduce the number of crisis calls about behavioral health in the four counties by 30%.	$1,000,000

Maternal/Child Mental Health: Identifying and Addressing Root Causes of Behavioral Concerns in Children	Green Bay	January, 2016 – December 2017	Improve service delivery for mental health diagnosis and care of children and mothers by creating common child behavioral and maternal post-partum depression screening processes, resulting in early detection and improved access to care.	$191,044 Plus $91,959 from RTTT-ELC
Fostering Futures: Transforming Child Welfare Policies/Practices Through Trauma-Informed Principles	Statewide	January 2016 – June 2018	Improve child and family health and well-being through integration of trauma-informed principles into Wisconsin's child welfare policies and practices in order to mitigate the short and long-term social, emotional and health effects of childhood toxic stress.	$326,619 Plus $105,000 fees from participating organizations
Healthier Children Through a Shared Service Network Supporting ASQ Screening/Early Intervention	Monroe and Vernon Counties	January 1, 2018 – June 30, 2021	The Kickapoo region is seeking systems change to increase child care availability and provider training. The Shared Resource Network will support screening, data-based decision making and early intervention for children.	$399,808
Gathering Resources and Aligning Community Engagement (GRACE Hub)	La Crosse County	July 1, 2017 – June 30, 2020	Implement a system to bridge the gap between health care delivery and the social service sector for cost savings, improved population health outcomes, and increased client experience and engagement.	$294,901
Transforming Primary Prevention Systems to Build Family Protective Factors	Kenosha County	July 1, 2017 – June 30, 2019	Embed strengths-based, evidence informed policies and practices throughout primary prevention systems in Kenosha County to build family Protective Factors, optimize child development and address causes of child maltreatment.	$298,600