Wisconsin Office of Children's Mental Health

2015 Report to the Wisconsin Legislature

TABLE OF CONTENTS

EXECUTIVE SUMMARY 2
INTRODUCTION 4
INNOVATE 5
INTEGRATE 7
IMPROVE 9
RECOMMENDATIONS 11
APPRECIATION 13

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EXECUTIVE SUMMARY

The Wisconsin Office of Children's Mental Health (OCMH) has a unique charge. Instead of focusing on program development or providing direct services, the OCMH was created to enhance communication within and between state agencies serving children and families, coordinate initiatives, and monitor program performance. Additionally, the OCMH is charged with identifying administrative efficiencies and improving access to services provided by the Department of Children and Families, Department of Corrections, Department of Health Services, the Department of Public Instruction, as well as county and community-based organizations serving Wisconsin's children.

The OCMH's *2014 Report to the Wisconsin Legislature*[1] set the stage for these activities by providing an overview of children's mental health in Wisconsin.[2] Based on the findings, the OCMH established three action-based categories to address identified issues: Innovate, Integrate, and Improve.

INNOVATE

Goal Statement: Systems, policies, and programs are driven by parents and youth with lived experience. The OCMH incorporates a public health approach to mental health that includes increasing awareness of Adverse Childhood Experiences (ACEs)[3] and promoting resilience.[4] To promote this goal in 2015, the OCMH:

- Supported parent and youth collective impact partners leadership and participation;
- Provided technical assistance to state agencies and other stakeholders committed to including parent and youth voice in policy and program development;
- Assisted the Department of Health Services in the development of certified parent peer specialists;
- Participated as a member of the Fostering Futures Steering Committee;
- Initiated a public/private partnership designed to raise awareness of the impact of ACEs and to promote resilience in a select number of workplaces.

INTEGRATE

Goal Statement: Children's mental health stakeholders create a unified vision, aligned goals, effective intervention, and shared metrics. To address this goal in 2015, the OCMH:

- Provided backbone support to the Children's Mental Health Collective Impact (CMHCI) leading to the solidification of the Children's Mental Health Collective Impact Executive Council and the creation of three workgroups;

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[1] http://legis.wisconsin.gov/lfb/jfc/reports/Documents/2015_01_02_OCMH.pdf

[2] Every three years the OCMH will provide an overview of various mental health-related metrics similar to those published in the OCMH's 2014 report. The next overview will be published in in 2017.

[3] http://wichildrenstrustfund.org/index.php?section=adverse-childhood

[4] http://resiliencetrumpsaces.org/

- Facilitated cross-state agency collaborative group meetings and distributed information outlining state agency partnership activities.

IMPROVE

Goal Statement: Services and supports are accessible and lead to recovery and resilience. In 2015, the OCMH led or participated in state-sponsored workgroups aimed at quality improvement and the provision of technical assistance to both state and county agencies in the following issue areas:

- Crisis response and youth psychiatric emergency detentions
- Youth suicides
- Antipsychotic prescribing patterns
- Racial disparities in child and youth outcomes
- School-based mental health
- Cross-system integration of trauma-informed care
- Infant mental health policy
- Mental health consultation for infants and toddler
- Mental health training for juvenile justice services
- Data collection and integration.

CONCLUSION

While much remains to be done, in 2015 OCMH staff made great strides in promoting the importance of parent and youth participation in policy-making, furthering collaboration, building a common infrastructure for action, and identifying data to help understand and successfully address challenges.

'There is significant power in Wisconsin's motto, "Forward." This concept is reflected in the Office of Children's Mental Health's focus on innovation, integration, and improvement.

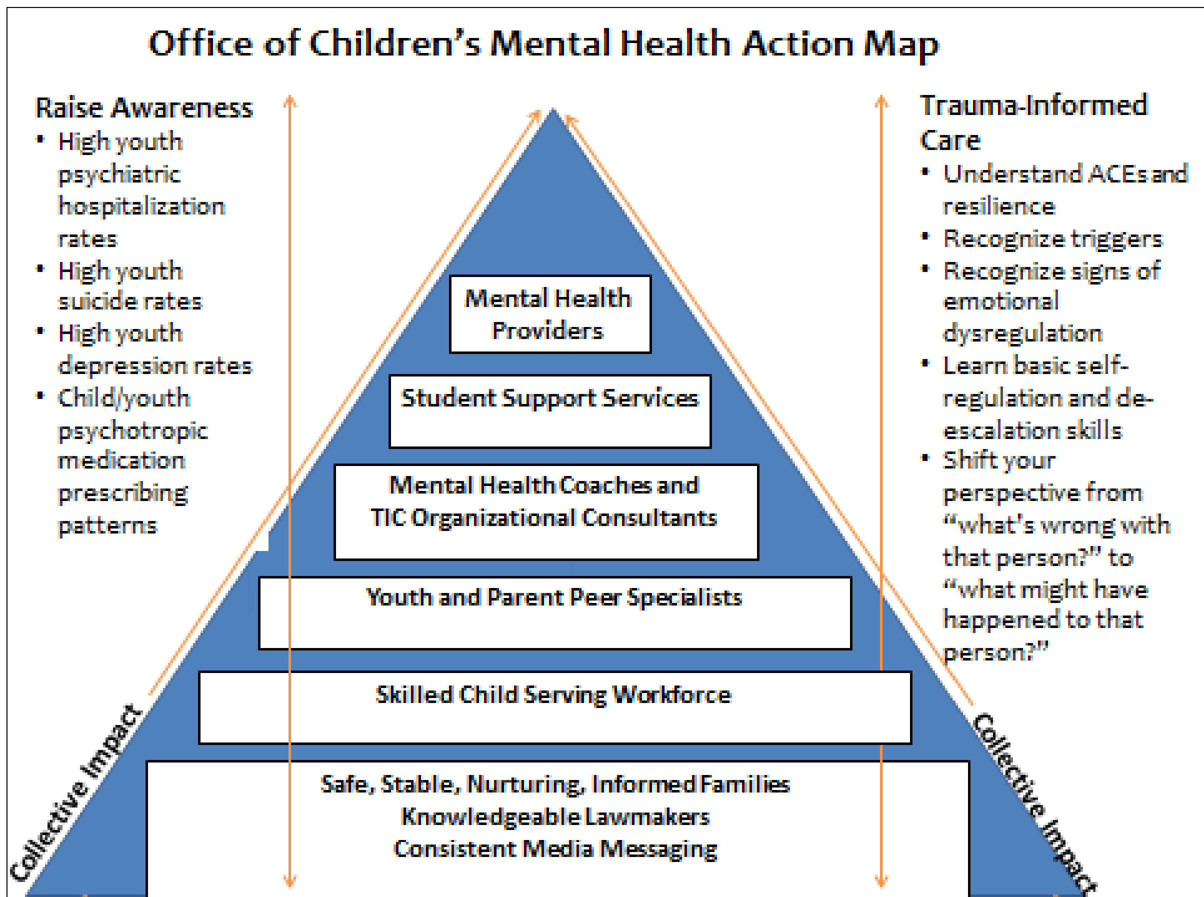
More specifically, the Children's Mental Health Collective Impact process is the epitome of what it is to move "Forward." As the backbone of this collective impact initiative, the OCMH facilitates a diverse group of people who are creating a forward direction that will lead to a healthier and more prosperous state for all who call Wisconsin home.'

- Tina Buhrow
Collective Impact Parent Partner

INTRODUCTION

2015 marked the first year that the Office of Children's Mental Health (OCMH) was fully staffed. Under the categories of innovation, integration and improvement, the OCMH staff supported the Children's Mental Health Collective Impact,[5] strengthened the influence of the Children's Mental Health Collective Impact parent and youth partners, disseminated data and recommendations about issues facing Wisconsin's children and families, won a competitive national grant, and met regularly with stakeholders to address a wide-range of issues impacting children and families.

The *Office of Children's Mental Health Action Map* (see diagram below) captures many the OCMH concepts. The triangle represents a public health approach,[6] the orange arrows indicate staff committment to promoting collective impact and trauma-informed care, and the left corner highlights some of Wisconsin's most pressing children's mental health issues. Activities related to these topics will be explained in more detail throughout the report. Additional details related to the OCMH activities may be found on the *OCMH Logic Model* (see Appendix A).



[5] See Appendix C1 and the following websites for more information about Collective Impact http://www.vee.org/wp-content/uploads/2013/10/collective-impact-basics.pdf http://ssir.org/articles/entry/collective_impact

[6] See OCMH's 2014 Annual Report (pages 6-8) for a description of the OCMH's public health approach to children's mental health http://legis.wisconsin.gov/lfb/jfc/reports/Documents/2015_01_02_OCMH.pdf

INNOVATE

Goal Statement: Systems, policies, and programs are driven by parents and youth with lived experience. OCMH incorporates a public health approach[7] that includes increasing awareness of Adverse Childhood Experiences (ACEs) and promoting children, family and community resilience. The following is a review of the OCMH's 2015 activities regarding this goal.

PARENT AND YOUTH INVOLVEMENT AND LEADERSHIP

Collective Impact Partners: The Family Relations Coordinator recruited and trained ten parents and four youth to serve on the Children's Mental Health Collective Impact (CMHCI) Executive Council and workgroups. Together, these Collective Impact Partners brought decades of lived experience to their participation and leadership in CMHCI Executive Council meetings and workgroups and are changing the content and tenor of state discussions about mental health and resilience. *The Collective Impact Partners' Language Guide* (see Appendix B-1) is one example of their work. With their guidance and support, state agencies will be able to better recognize gaps in services, failing programs and unhelpful or cumbersome policies and practices.

State Infrastructure for Parent and Youth Leadership: The Family Relations Coordinator helped state agencies build an infrastructure for parent and youth involvement extending beyond collective impact. This effort took the form of the group called Leading Together, an initiative bringing parent perspectives into program and policy discussions focused on mental health, education, child welfare, and juvenile justice (see Appendix B-2). Drawing on the work of existing family and peer agencies, Leading Together will recruit and train parents to participate in and lead state agencies' workgroups and committees.

Technical Assistance and Training to State Activities: The Family Relations Coordinator provided a lived experience perspective to many state initiatives including the following:

- Review of the Department of Children and Families Child Welfare Practice Model;
- Training on trauma-informed care to teachers for deaf and hard of hearing students through the Department of Health Services (DHS) Deaf and Hard of Hearing Steering Committee;
- Participation in the development of the DHS parent peer specialist state certification;
- Initiation of the Department of Public Instructions (DPI) Parent Advisory Workgroup;
- Participation in the DPI Trauma Sensitive Schools workgroup and the Safe Schools/Healthy Students Family Engagement Workgroup;
- Participation as a core team member of a cross-agency Juvenile Justice Policy Academy aimed at diverting youth with trauma and/or mental health issues from the juvenile justice system.

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[7] Additional information can be found in the following document, *A Public Health Approach to Children's Mental Health: A Conceptual Framework* http://gucchdtacenter.georgetown.edu/publications/PublicHealthApproach.pdf

INCREASE AWARENESS OF THE IMPACT OF ACEs AND THE POWER OF RESILIENCE

Mobilizing Action for Resilient Communities: Early in 2015, the Health Federation of Philadelphia (with support from the Robert Wood Johnson Foundation and The California Endowment) asked the OCMH to apply for a competitive grant to expand Wisconsin's innovative work in addressing ACEs. The OCMH's application was subsequently chosen (see Appendix B-3) and will focus on introducing ACEs information and strategies to increase resilience in select workplaces. The OCMH will provide oversight and distribute the funding ($150,000) to Wisconsin's contractual partners (e.g., Branch2,[8] Center for Investigating Healthy Minds,[9] and SaintA[10]).

By bringing this information to the general population, Wisconsin will move towards a universal understanding of ACEs and resilience.

> *"These states and cities [award recipients] are living laboratories that can teach all of us what it takes to transform cycles of trauma into a Culture of Health. Anyone who is interested in strengthening the resilience of their community should pay attention to what these communities are doing."*
>
> \- Martha B. Davis
> Robert Wood Johnson Foundation

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[8] http://branch2.com/
[9] http://www.investigatinghealthyminds.org/
[10] http://www.sainta.org/

INTEGRATE

Goal Statement: Stakeholder collaboration leads to a unified vision, aligned goals, shared metrics, and successful outcomes. The following is a review of the OCMH's 2015 activities regarding this goal.

Children's Mental Health Collective Impact (CMHCI) Backbone: Collective impact literature outlines that in order to maintain a vital collective impact change process, there must be "a separate organization dedicated to coordinating the various dimensions and collaborators involved in the initiative."[11] [12] OCMH enthusiastically assumed this role which, in collective impact parlance, is called "the backbone organization."

Children's Mental Health Collective Impact (CMHCI) Executive Council: The OCMH planned and facilitated eleven CMHCI Executive Council meetings during which the group developed a common mission ("We will create an integrated system of care"), a statement of hope ("Every child is safe, nurtured and supported to promote optimal health and well-being"), and three workgroups. Additionally, the Executive Council began examining the allocation of state resources in order to identify opportunities to blend or braid funding with the goal of reducing service silos and increasing efficiency in financial spending (see Appendices C-2a through C-2f). At the close of the year, the CMHCI stakeholders created a list of policy-related activities they believe would promote socially and emotionally healthy children and families (see Appendix C-3).

"Our AWARE grant activities were greatly influenced by the Children's Mental Health Collective Impact. Being a participant in this process led our team to align the direction of our project to reflect state-wide priorities and leverage new federal money to achieve the greatest impact for children and families in Wisconsin."

- Monica Wightman
Advancing Wellness and Resiliency Education (AWARE)
Department of Public Instruction

CMHCI Workgroups: The CMHCI Executive Council established three workgroups with the following goals.

- Access Workgroup Goal Statement: Wisconsin's children, youth, and families have timely access to high quality, trauma-informed, culturally appropriate mental health services that promote children's social and emotional development. In 2015, this group began to identify barriers to access, strategies to remove the barriers, and outcome measures to track progress.

[11] http://www.collaborationforimpact.com/collective-impact/the-backbone-organisation/
[12] http://ssir.org/articles/entry/does_your_backbone_organization_have_backbone?

- Trauma-Informed Care (TIC) Workgroup Goal Statement: 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-economic status. This group will adapt and distribute a trauma-informed care implementation framework from Missouri (see Appendix C-4). To assist this group and other stakeholders in recognizing the current scope of counties' TIC transformation, OCMH coordinated the collection of TIC implementation information from county human service directors and tribes (see Appendix C-5).

- Resilience Workgroup Goal Statement: All Wisconsin's children, youth and their families have accurate and timely information and the supports needed for social emotional development, optimal mental health and resilience, including relationships and social networks that provide friendship, love and hope. This group established a culturally-informed definition of resilience and identified state-level activities focused on developing resilience in children and families. WestEd, an organization supporting the Department of Public Instruction, provided this group with a national scan of related activities.

State Agency Stakeholder Collaboration: The OCMH held bi-monthly meetings with leadership from the Department of Children and Families, the Department of Corrections, the Department of Health Services, and the Department of Public Instruction in order to foster collaboration and exchange information about activities related to children's mental health. To keep stakeholders up-to-date on collaborative activities, the OCMH created a living document describing joint projects and initiatives (see Appendix C-6).

IMPROVE

Goal Statement: Services and supports are accessible and lead to children and families' recovery and resilience. The following is a review of the OCMH activities regarding this goal.

Psychiatric Hospitalizations and Crisis Response: The OCMH facilitated the Children's Emergency Detention and Crisis Services (CEDCS) Workgroup. Over the course of five meetings, this group accomplished the following:

- Reviewed data on hospitalizations and youth access to outpatient mental health services;
- Received background information and updates regarding areas of greatest need, crisis grants and regional collaborations;
- Developed a list of recommendations.

"It's been very helpful to have the Office of Children's Mental Health present counties and providers with data about what's happening with kids in our public mental health system, especially regarding psychiatric hospitalizations."

- Iris Ostenson
Emergency Services Director
Northwest Connections

From the list of recommendations, three smaller workgroups were created to accomplish the following:

- Collect and disseminate crisis services best practices to all counties;
- Create a standard training for county staff for state-wide quality assurance;
- Design and pilot a regional group home that can be used in lieu of hospitalization for the purposes of crisis stabilization.

The CEDCS Workgroup will reconvene in April 2016 to review accomplishments and identify next steps (see Appendices D1 through D3 for a collection of the CEDCS related documents).

Psychotropic Drugs: The OCMH participated in a workgroup created by the Department of Health Services (DHS) and the Department of Children and Families (DCF) focused on learning about psychotropic drug prescribing practices for children on Medicaid as well as children in foster care. The information was gathered by linking Medicaid claims and prescription data with foster care enrollment data to analyze prescribing patterns and non-pharmacological therapies.

In addition, group members shared information related to:

- DHS project requiring prior authorization before prescribing antipsychotics to children seven years of age and younger;
- DHS project which identified children on high doses of stimulants followed by prescriber education regarding best practices in children's stimulant dosing;
- Care4Kids project developed quality measures in polypharmacy and antipsychotic metabolic monitoring.

Disparities: The OCMH has found that all of Wisconsin's child-serving systems contend with racial disparities. To deepen understanding of this issue, the OCMH convened two meetings which included representation from the Department of Children and Families, the Department of Corrections, the Department of Health Services, the Department of Justice, and the Department of Public Instruction. The meetings revealed varied approaches to the addressing disparities. The OCMH followed up these discussions with a presentation focused on historical trauma and its impact on racial minority groups. The OCMH anticipates that this important issue will be addressed by the Children's Mental Health Collective Impact Resilience Workgroup.

School-based Mental Health Services: As noted in the OCMH 2014 report, school-based mental health is viewed by many as a solution to many of the barriers facing children and families seeking mental health services. As was also noted, successful implementation of this model is contingent on the supportive qualities of the school culture[13] and increasing the schools' commitment to trauma sensitivity.[14] Other elements include teacher and parent consultation to ensure that the child's skill development is reinforced in home and classroom environments and those connections are made with community services and supports. To this end, the OCMH participated in related efforts sponsored by the Department of Public Instruction (e.g., Safe Schools/Healthy Students State Management Team and Advancing Wellness and Resilience Education initiative),[15] and also provided consultation to the Coalition for Advancing School-Based Mental Health.

Infant Mental Health: The OCMH hosted the Infant-Toddler Policy Committee, facilitated by the Wisconsin Alliance for Infant Mental Health, focused on raising awareness of infant mental health in early care and education, medical, and human services systems.

Data Analysis Workshops: The OCMH organized five informational workshops for state agency employees with attendance ranging from 40-60 participants. These workshops were recorded and posted online[16] and addressed the following topics:

- Data visualization techniques
- Tracking trends
- Isolating causal effects
- Designing web-based surveys
- Matching records across data sources.

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[13] http://rti.dpi.wi.gov/rti_pbis.
[14] http://sspw.dpi.wi.gov/sspw_mhtrauma.
[15] https://dpi.wi.gov/news/releases/2015/wisconsin-school-mental-health-project-gets-under-way
[16] Matching Records Across Data Sets, http://dhsmedia.wi.gov/main/Play/476718d6b381455f9f6c6a61588543a51d?catalog=f0c85e73-f28e-44e5-bb5c-af9a1148988a
The Nuts and Bolts of Web Surveys, http://dhsmedia.wi.gov/main/Play/4c9c80bafd284dd2998ec566d70763451d?catalog=f0c85e73-f28e-44e5-bb5c-af9a1148988a
Time and Causality, http://dhsmedia.wi.gov/main/Play/64af3da3b7fe48b4af810c32cc1803851d?catalog=f0c85e73-f28e-44e5-bb5c-af9a1148988a

RECOMMENDATIONS

To further the momentum in improving the lives of children and families in Wisconsin, the Office of Children's Mental Health (OCMH) offers the following recommendations.

1. **Use 2013 Senate Joint Resolution 59 as a guide to create and/or examine legislative, state agency, and county policy**

With the passage of 2013 Senate Joint Resolution 59,[17] Wisconsin became a national leader in defining a role for legislators in the promotion of healthy early brain development.[18] Specifically, the resolution advises that, "policy decisions enacted by the Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships…"

The OCMH recommends that this resolution, along with the guidance offered in *The Science of Early Brain Development: A Foundation for the Success of Our Children and the State Economy,*[19] become central tools for legislators and other policy makers committed to reducing children's exposure to toxic stress and increasing children's resilience. As such, the OCMH will sponsor several workshops in 2016 outlining how to use this resolution to examine policy proposals.

2. **Establish Wisconsin-specific indicators to monitor children's mental health**

In order to monitor Wisconsin's progress in meeting children's mental health needs, the OCMH will establish, in collaboration with stakeholders, a list of Wisconsin-based indicators that will represent the overall status of children's mental health in Wisconsin.

3. **Develop strategies to further create, develop, and sustain an integrated child and family-serving data system that includes service outcomes**

Wisconsin state agencies are rich with information related to the well-being of Wisconsin's children and families. Despite the extent of Wisconsin's data collection, there are challenges that prohibit much of the data from being used for predictive analytics, policy analysis, system recommendations, and quality improvement. These challenges include the following: data is largely isolated within each state agency and not designed to interface with other datasets; many state programs lack data on outcomes; many services are offered through counties with minimal information filtering to the state; and, with some exceptions, there is a lack of standard protocol for how to access available data.

[17] http://docs.legis.wisconsin.gov/2013/related/proposals/sjr59
[18] http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0151-0200/acr_155_bill_20140528_introduced.htm
[19] https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis32report.pdf

Many divisions across the Department of Children and Families, the Department of Corrections, the Department of Health Services, and the Department of Public Instruction have or are undertaking efforts to address some of these issues. For instance, the Department of Children and Families has established public-facing, interactive dashboards and regularly publishes performance reports,[20] and, notably for children's mental health and the reduction of data silos, the Department of Children and Families and the Department of Public Instruction's *Race to the Top Early Learning Challenge* grant[21] is initiating an Early Childhood Integrated Data System (ECIDS).[22] With regard to data standardization, the Department of Corrections is moving towards a data system that will allow its juvenile justice data to interface with its adult inmate data. The Department of Health Services is working to integrate Medicaid and mental health and substance abuse data. Additionally, the Department of Public Instruction has created a data governance structure which is very user-friendly.

The OCMH recommends that state leadership support current efforts while also pursuing a truly integrated child and family-serving data system that prioritizes the inclusion of service outcomes within all data collection activities.

[20] http://www.dcf.wisconsin.gov/cqireview/index.htm
[21] http://dcf.wisconsin.gov/rttt/
[22] http://dcf.wisconsin.gov/rttt/dcf_project_10.htm

APPRECIATION

The following people have dedicated a great deal of time and attention to ensuring that the Office of Children's Mental Health (OCMH) goals and activities are successful and that the OCMH efforts translate into the improvement of the lives of Wisconsin's children and families.

Children's Mental Health Collective Impact Executive Council

Name	Organization
Joyce Allen	Department of Health Services
Micheal Bostrom	Collective Impact Youth Partner
Fredi Bove	Department of Children and Families
Paula Buege	Collective Impact Parent Partner
Tina Buhrow	Collective Impact Parent Partner
Susan Cochran	Department of Health Services
Kimberlee Coronado	Collective Impact Parent Partner
Kim Eithun	Office of Children's Mental Health
Terri Enters	Department of Health Services
Mina Esser	Collective Impact Parent Partner
Catherine Foster	Collective Impact Parent Partner
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Phyllis Greenberger	Disability Rights Wisconsin
Linda Hall	Wisconsin Association of Families and Children's Agencies
Jennifer Hammel	Children's Hospital of Wisconsin
Crystal Hanson	Anu Family Services
Judie Hermann	Department of Children and Families
Jon Hoelter	Department of Health Services
Jill Hoiting	Supporting Families Together Association
Elizabeth Hudson	Office of Children's Mental Health
Cheryl Jatczak	Department of Health Services
Michelle Jensen Goodwin	Wisconsin Child Abuse and Neglect Prevention Board
Sheri Johnson	Medical College of Wisconsin
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Doug White	Department of Public Instruction
Alison Wolf	Collective Impact Parent Partner

Children's Mental Health Collective Impact Partners

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Mina Esser
Catherine Foster
Robert Kaminski
Zofia Kaminski
Corbi Stephens
Kathy Mullooly
Sarah Tweedale
Susana Valdez-Shogren
Alison Wolf

Children's Mental Health Collective Impact Workgroup Members

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Linda McCart	Department of Health Services

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Kelsey Hill	Department of Corrections
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APPENDICES

INTRODUCTION

Appendix A:		*OCMH Logic Model*

INNOVATE

Appendix B:	B-1	*Collective Impact Partners' Language Guide*
	B-2	*Framework for Parent and Youth Leadership*
	B-3	*OCMH and Health Federation MARC Press Releases*

INTEGRATE

Appendix C:	C-1	*Collective Impact*
	C-2a-2f	*State Agencies' and Tribal Financial Tables*
	C-3	*Children's Mental Health Collective Impact Recommendations*
	C-4	*Missouri Model of Trauma-Informed Care Implementation*
	C-5	*TIC and EBP County and Tribal Activity Table*
	C-6	*System Collaboration Table*

IMPROVE

Appendix D:	D-1	*Emergency Detention FAQ*
	D-2	*CEDCS Workgroup Summary*
	D-3	*CEDCS Workgroup Recommendations*
	D-4	*Crisis Response Continuum of Services*

Appendix A: OCMH Logic Model

Wisconsin's Office of Child Mental Health Logic Model (2015-2016)

Problem: Child and family services focused on social, emotional and mental health are often inaccessible and reactive. Services often lack coordination, outcome data, parent and youth input, cultural competence and a trauma-informed orientation.

Target Population: OCMH was created to serve state agencies, tribes, legislators and policy makers that serve children and families.

Vision: OCMH's vision is that Wisconsin's children are safe, nurtured and supported to achieve their optimal mental, social and emotional well-being.

Mission: OCMH's mission is to innovate, integrate and improve Wisconsin's human service systems resulting in thriving children, youth and families.

Guiding Principles: Family and youth lead system • Stakeholder collaboration leads to efficiency, effectiveness and cost-reduction • Systems share common goals and metrics • Best and promising practices are available in the right place at the right time • Services are tailored to the child and family and respect the child and family's unique cultural heritage • Systems and services are trauma-informed • Services promote family and youth connections to natural supports • Decision-making is grounded in science, information and evaluation

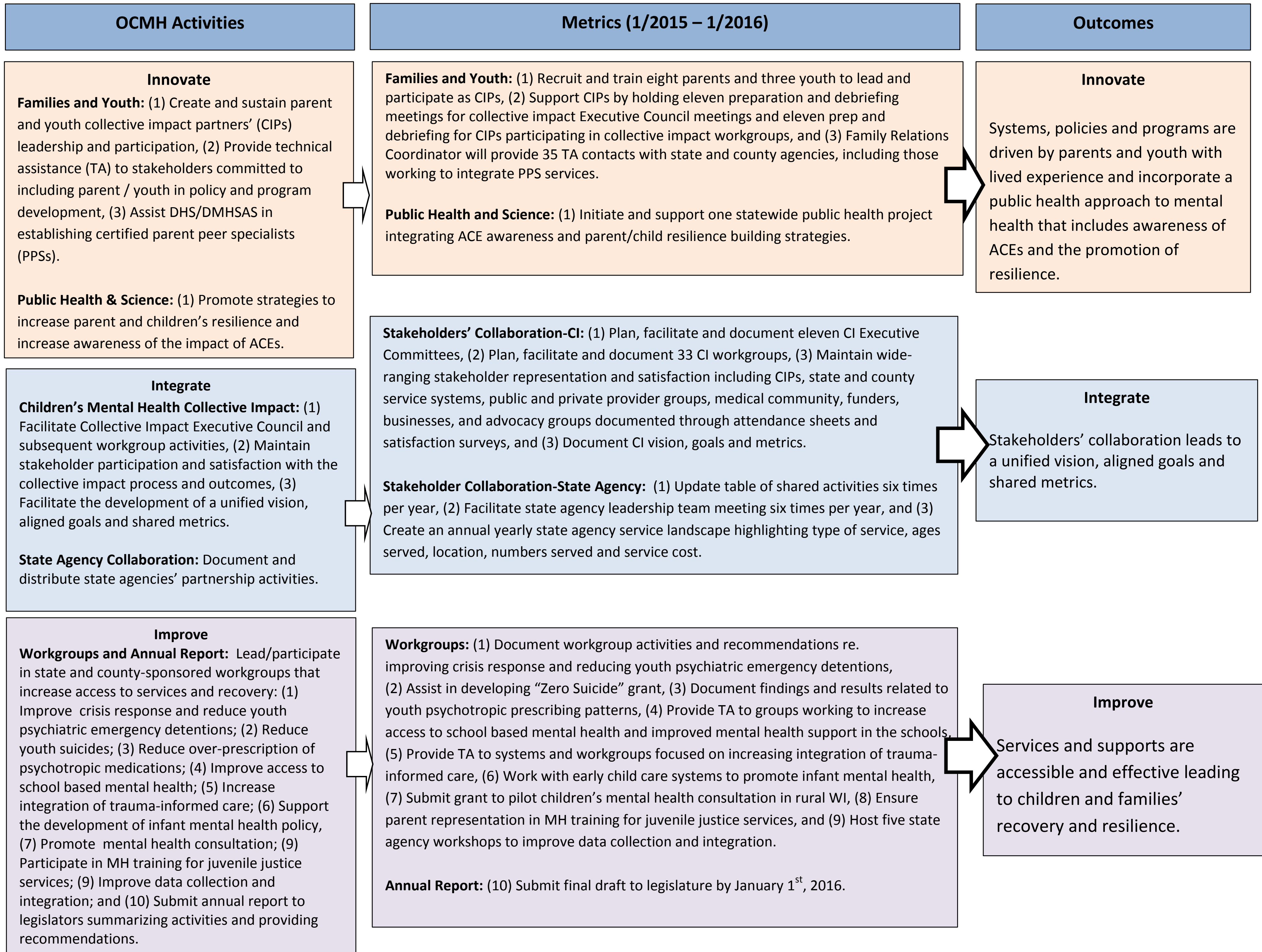
Gaps: Gaps in Resources: Provider shortage

Gaps in Systems' Knowledge: TIC and ACE awareness are not integrated across all service systems and programs • Limited awareness of the importance of including parent and youth with lived experience in policy and program development

Gaps in Data and Information Sharing: Lack of integrated data system • Lack of outcomes across child and family serving systems • Inconsistent county service reporting • Disparity (racial, socio-economic) in existing outcome measures and no systematic, cross departmental strategy to reduce disparities

Inputs: OCMH Staff (4) • Government agencies • Stakeholders (parents/youth with lived experience, county and regional partners, mental health provider groups, private sector/businesses, hospitals/pediatricians/medical providers, advocacy groups, higher education) • Schools • Financial and community resources • Evidence-based practices/policy • Policy makers • Data and technology systems

Goals: **Innovate:** Parents and youth with lived experiences drive systems, policies and programs. OCMH incorporates a public health approach to mental health that includes ACE awareness and the promotion of resilience.
Integrate: Stakeholders collaborate to create a unified vision, coordinated services, aligned goals, shared metrics, and successful outcomes.
Improve: Services and supports are accessible and effective leading to children and families' recovery and resilience.


OCMH Activities
Metrics (1/2015 – 1/2016)
Outcomes
Innovate
Families and Youth: (1) Create and sustain parent and youth collective impact partners' (CIPs) leadership and participation, (2) Provide technical assistance (TA) to stakeholders committed to including parent / youth in policy and program development, (3) Assist DHS/DMHSAS in establishing certified parent peer specialists (PPSs).
Public Health & Science: (1) Promote strategies to increase parent and children's resilience and increase awareness of the impact of ACEs.
Families and Youth: (1) Recruit and train eight parents and three youth to lead and participate as CIPs, (2) Support CIPs by holding eleven preparation and debriefing meetings for collective impact Executive Council meetings and eleven prep and debriefing for CIPs participating in collective impact workgroups, and (3) Family Relations Coordinator will provide 35 TA contacts with state and county agencies, including those working to integrate PPS services.
Public Health and Science: (1) Initiate and support one statewide public health project integrating ACE awareness and parent/child resilience building strategies.
Innovate
Systems, policies and programs are driven by parents and youth with lived experience and incorporate a public health approach to mental health that includes awareness of ACEs and the promotion of resilience.
Integrate
Children's Mental Health Collective Impact: (1) Facilitate Collective Impact Executive Council and subsequent workgroup activities, (2) Maintain stakeholder participation and satisfaction with the collective impact process and outcomes, (3) Facilitate the development of a unified vision, aligned goals and shared metrics.
State Agency Collaboration: Document and distribute state agencies' partnership activities.
Stakeholders' Collaboration-CI: (1) Plan, facilitate and document eleven CI Executive Committees, (2) Plan, facilitate and document 33 CI workgroups, (3) Maintain wide-ranging stakeholder representation and satisfaction including CIPs, state and county service systems, public and private provider groups, medical community, funders, businesses, and advocacy groups documented through attendance sheets and satisfaction surveys, and (3) Document CI vision, goals and metrics.
Stakeholder Collaboration-State Agency: (1) Update table of shared activities six times per year, (2) Facilitate state agency leadership team meeting six times per year, and (3) Create an annual yearly state agency service landscape highlighting type of service, ages served, location, numbers served and service cost.
Integrate
Stakeholders' collaboration leads to a unified vision, aligned goals and shared metrics.
Improve
Workgroups and Annual Report: Lead/participate in state and county-sponsored workgroups that increase access to services and recovery: (1) Improve crisis response and reduce youth psychiatric emergency detentions; (2) Reduce youth suicides; (3) Reduce over-prescription of psychotropic medications; (4) Improve access to school based mental health; (5) Increase integration of trauma-informed care; (6) Support the development of infant mental health policy, (7) Promote mental health consultation; (9) Participate in MH training for juvenile justice services; (9) Improve data collection and integration; and (10) Submit annual report to legislators summarizing activities and providing recommendations.
Workgroups: (1) Document workgroup activities and recommendations re. improving crisis response and reducing youth psychiatric emergency detentions, (2) Assist in developing "Zero Suicide" grant, (3) Document findings and results related to youth psychotropic prescribing patterns, (4) Provide TA to groups working to increase access to school based mental health and improved mental health support in the schools, (5) Provide TA to systems and workgroups focused on increasing integration of trauma-informed care, (6) Work with early child care systems to promote infant mental health, (7) Submit grant to pilot children's mental health consultation in rural WI, (8) Ensure parent representation in MH training for juvenile justice services, and (9) Host five state agency workshops to improve data collection and integration.
Annual Report: (10) Submit final draft to legislature by January 1st, 2016.
Improve
Services and supports are accessible and effective leading to children and families' recovery and resilience.

Appendix B-1: CIP Language Guide

Wisconsin Children's Mental Health Collective Impact Partners (CIPs) Language Guide 2015

Deficit-Based Language	Strength-Based, Recovery-Oriented, Person-First, Trauma-Informed Alternative
Describing a Person	
Schizophrenic, a borderline, bipolar	Person diagnosed with…, person who experiences the following…, in recovery from…
Addict, junkie, substance abuser	Person who uses substances; a person with substance use issues
Consumer, patient, client	Person in recovery, a person working on recovery, a person participating in services
Frequent flyer, super utilizer	Frequently uses services and supports, is resourceful, a good self-advocate, attempts to get needs met
Describing Behavior	
Good / bad, right / wrong	Different, diverse, unique
High- vs. low-functioning	Doing well vs. needs supports
Suffering from	Person is experiencing, living with, working to recover from
Acting-out, "having behaviors"	Person's behaviors may indicate a trauma memory has been triggered, person is upset
Attention-seeking	Seeking to get needs met, seeking assistance to regulate
Criminogenic, delinquent, dangerous	Specify unsafe behavior, utilizing unsafe coping strategies
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis, person sees themselves in a strength based way (Honor the individual's perception of self)
Manipulative	Resourceful, trying to get help, able to take control in a situation to get needs met, boundaries are unclear, trust in relationship has not been established
Oppositional, resistant, non-compliant, unmotivated	Constraints of the system don't meet the individual's needs, preferred options are not available, services and supports are not a fit for that person (Assume that people do well if they can)
DTO, DTS, GD (Danger to Others, Danger to Self, General Danger)	People should not be reduced to acronyms; describe behaviors that are threatening
Entitled	Person is aware of her/his rights, empowered
Puts self and/or recovery at risk	Person is trying new things that may have risks
Weakness, deficits	Barriers, needs, opportunity to develop skills

Information adapted from Tondora, et al., Yale University School of Medicine Program for Recovery and Community Health, 2007

Deficit-based Language	Strength-Based, Recovery Oriented, Person-First, Trauma Informed Alternative
Describing Service Activity	
Baseline	Self-determined quality of life that was established at the first meeting
Clinical decompensation, relapse, failure	Crisis as an opportunity to develop and or apply coping skills and to draw meaning from an adverse event; recovery is not linear - relapse is expected and support is increased as necessary
Discharged to aftercare	Person is connected to long-term recovery support
Maintaining clinical stability, abstinence	Promoting and sustaining recovery, building resilience
Minimize risk	Maximize growth, presume competency
Non-compliant with medications, treatment	Person prefers alternative strategies, therapies and interventions; not reliant on medical model treatment; has a crisis or WRAP plan; person is thinking for herself
"Treatment works"	Person uses treatment to support his/her recovery
Case manager	Recovery coach, recovery guide, recovery support, care coordinator ("I'm not a case, and you're not my manager")
Enable	Empower through empathy, emotional authenticity, and encouragement
Front-line staff, "in the trenches"	Avoid using war metaphors and develop language that promotes strong relationships
Treatment team	Recovery team, recovery support system, care team

Parents and Youth with Lived Experience

Parent, Family and Youth Run Organizations and Training Opportunities

Recruitment

Additional Training / Opportunities

OCMH Matching and Support

State and County Agency Activities

Trainings

Document reviews

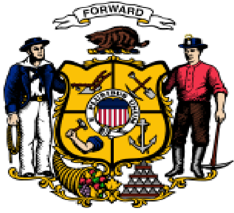
Councils

Work-groups

Legislative groups

Program & policy reviews

Certified Parent Peer Specialists within child serving agencies



Office of Children's Mental Health

Appendix B-3: MARC Press Release

State of Wisconsin

Scott Walker, Governor
Elizabeth Hudson, Director

FOR IMMEDIATE RELEASE
November 5, 2015
Contact: Elizabeth Hudson, Elizabeth.Hudson@wi.gov (608) 266-2771

Wisconsin's *Children's Mental Health Collective Impact Coalition* Poised to Bring "ACEs" Awareness and Mindfulness to the Workplace

Madison –Wisconsin has been chosen as one of fourteen communities from across the country to expand their innovative work in addressing childhood adversity through a new project launched by The Health Federation of Philadelphia, with support from the Robert Wood Johnson Foundation and The California Endowment.

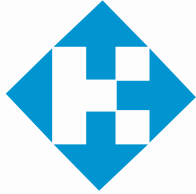
Called "Mobilizing Action for Resilient Communities" (MARC), the project supports communities building the movement to create a just, healthy and resilient world. It will foster solutions to prevent traumatic childhood experiences — like neglect, abuse and abandonment — in families throughout the nation. Known as Adverse Childhood Experiences (ACEs), these events have been proven to have lifelong impacts on children's health and behavior and the communities they live in.

The Office of Children's Mental Health (OCMH) serves as the "backbone" agency supporting the Collective Impact Coalition and will distribute the funding to the MARC project partners. "MARC is the opportunity we've been waiting for," states Elizabeth Hudson, Director of the OCMH. "By bringing this information to the workplace, we are heeding the call to adopt a universal, public health approach to address toxic stress and build resilient communities."

Wisconsin's proposal outlines a two year public-private initiative bringing together multiple partners including Branch2, a technology company. "It's a privilege to be a partner on this project," said Branch2 CEO Reggie Luedtke. "We think the issues at stake here are paramount to building healthy communities and we're excited to work with OCMH, the Center for Investigating Healthy Minds and others, to deploy smartphone-based mindfulness programs at worksites around the state. It's a great opportunity to build awareness around ACEs and measure the impact on community wellbeing."

Other central partners include University of Wisconsin's Center for Investigating Healthy Minds, SaintA, Wisconsin's Children and Families' Collective Impact Coalition, and the Wisconsin Economic Development Corporation. Together, this group will pilot an ACEs and resilience workplace curriculum where, after learning about the impact of adversity and toxic stress, workplace participants will be given the option to participate in a research-based "resilience-building" mindfulness practice. Doing so will promote both an awareness of ACEs and a culture of health which will help reduce risk factors and boost resilience for Wisconsin families.

"These states and cities are living laboratories that can teach all of us what it takes to transform cycles of trauma into a Culture of Health," said Martha B. Davis, senior program officer for the Robert Wood Johnson Foundation. "Anyone who is interested in strengthening the resilience of their community should pay attention to what these communities are doing."



The
HEALTH FEDERATION
of Philadelphia

October 29, 2015
For Immediate Release

Contact: Clare Reidy
(215) 567-8001 x3014

Communities Poised to Expand Groundbreaking Work in Childhood Trauma

14 Localities to Join National Initiative on Adversity and Resilience Launched by The Health Federation of Philadelphia

Philadelphia, PA — Fourteen communities from across the country now have an opportunity to expand their innovative work in addressing childhood adversity through a new project launched by The Health Federation of Philadelphia, with support from the Robert Wood Johnson Foundation and The California Endowment.

Called Mobilizing Action for Resilient Communities (MARC), the project supports communities building the movement to create a just, healthy and resilient world. It will foster solutions to prevent traumatic childhood experiences — like neglect, abuse and abandonment — in families throughout the nation. Known as Adverse Childhood Experiences (ACEs), these events have been proven to have lifelong impacts on children's health and behavior and the communities they live in.

Each of the 14 communities — which range from Tarpon Springs, FL, to Alaska — will receive grants of $100,000-$300,000 and join a two-year learning collaborative where they will share best practices, try new approaches and become models for other communities in implementing effective solutions for combating ACEs. (The full list of communities and states can be found at the end of this release.)

"There can be no Culture of Health without preventing or healing the impact of childhood adversity and trauma," said Natalie Levkovich, CEO of The Health Federation. "The 14 communities selected for MARC are leading the nation's most innovative efforts to reduce ACEs and promote resilience."

Already, the communities have made significant strides in addressing childhood trauma, most by forming diverse coalitions across sectors that bridge the work of health care and social service providers, educators, policy-makers, law enforcement officials, business leaders and community members.

Most importantly, all communities have raised awareness of the significant impact ACEs have on children and families, which a growing body of research shows can leave long term tracks on the developing brain.

"These states, counties and cities are living laboratories that can teach all of us what it takes to transform cycles of trauma into a Culture of Health," said Martha B. Davis, senior program officer for the Robert Wood Johnson Foundation. "Anyone who is interested in strengthening the resilience of their community should pay attention to what these communities are doing."

The project's advisors include leading researchers, health care providers and policy-makers in the field of ACEs and resilience. The first face-to-face gathering of MARC collaborative members and advisors will take place in Philadelphia, November 9-10, 2015.

The following is a list of communities, their networks and backbone organizations, selected to be part of the MARC initiative:

- **ALASKA** — Alaska Resilience Initiative (Alaska Children's Trust)
- **ALBANY, NY** — The HEARTS Initiative for ACE Response (University at Albany Foundation)
- **BOSTON, MA** — Vital Village Community Engagement Network (Boston Medical Center)
- **BUNCOMBE COUNTY, NC** — Buncombe County ACEs Collaborative (Buncombe County Health and Human Services)
- **THE DALLES, OR** — Creating Sanctuary in the Columbia River Gorge (Columbia Gorge Health Council)
- **ILLINOIS** — Illinois ACEs Response Collaborative (United Way of Metropolitan Chicago)
- **KANSAS CITY, MO** — Trauma Matters KC (Chamber of Commerce of Greater Kansas City Foundation)
- **MONTANA** — Elevate Montana (ChildWise Institute)
- **PHILADELPHIA, PA** — Philadelphia ACE Task Force (Scattergood Foundation)
- **SAN DIEGO, CA** — San Diego Trauma Informed Guide Team & Building Healthy Communities Central Region (Harmonium, Inc.)
- **SONOMA COUNTY, CA** — Sonoma County ACEs Connection (County of Sonoma, Department of Health Services)
- **TARPON SPRINGS, FL** — Peace4Tarpon, Trauma Informed Community (Local Community Housing Corporation)
- **WASHINGTON** — ACEs/Resilience Team & Children's Resilience Initiative (Whatcom Family and Community Network)
- **WISCONSIN** — Wisconsin Collective Impact Coalition (Wisconsin Office of Children's Mental Health)

About the Health Federation of Philadelphia: The Health Federation of Philadelphia is a public health organization whose mission is to improve access to and quality of health care services for underserved and vulnerable individuals, families and communities. The organization coordinates and convenes a network of the community health centers in Southeastern Pennsylvania, and is the hub for issue-specific collaboratives such as the Philadelphia ACE Task Force. The Health Federation also delivers organizational consultation, professional development, technical assistance and training around many public health issues; mentors future public health professionals through its National Health Corps program; and runs innovative direct services programs for families in need. For more information about the Health Federation of Philadelphia, please visit www.healthfederation.org.

Collective Impact: Collective impact[1] is an innovative and 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. This approach consists of five characteristics which include (1) a common agenda, (2) a shared measurement system, (3) mutually reinforcing activities, (4) continuous communication, and (5) a backbone organization.

Collective impact differs from more conventional change methods in several ways. For instance, organizations are typically evaluated on their isolated work. *The Stanford Social Innovation Review* calls this, isolated impact.[2] Unfortunately, it is impossible for one single organization to solve highly complex social problems. Instead, complex problems require cross-sector collaborations to address the interplay between government agencies, private for profit businesses, non-profits, educational institutions, and, most significantly, people who are directly impacted by the social issues being addressed. Early adopters report that the success of collective impact initiatives requires a shift in how programs are designed and implemented, how funders operate, and how policies are developed.

Theory of Change (TOC): Another difference in the collective impact approach is the use of the Theory of Change method which used for planning, participating, and evaluating long-term goals while also outlining causal links (e.g., showing each outcome in logical relationship to all the others) and then mapping backwards to identify necessary preconditions.[3]

TOC differs from the more commonly used logic model in several ways. TOC links outcomes and activities to explain how and why the desired change is expected, while a logic model illustrates program components and helps stakeholders clearly identify outcomes, inputs and activities. TOC is best used when starting with a goal before deciding what programmatic approaches are needed versus a logic model which typically starts with a program. Lastly, TOC requires justifications at each step demonstrating why activities are expected to produce outcomes, while logic models require the existence of program components and outcomes which are then examined as in or out of sync with inputs and activities.

[1] http://www.vee.org/wp-content/uploads/2013/10/collective-impact-basics.pdf
[2] http://ssir.org/articles/entry/collective_impact
[3] http://www.theoryofchange.org/wpcontent/uploads/toco_library/pdf/TOCs_and_Logic_Models_forAEA.pdf
http://www.hfrp.org/evaluation/the-evaluation-exchange/issue-archive/evaluation-methodology/an-introduction-to-theory-of-change
http://www.theoryofchange.org/wpcontent/uploads/toco_library/pdf/TOCs_and_Logic_Models_forAEA.pdf

Funding Title	Purpose	Amount	Total Amount
Children and Family Aids (2014 - 15)	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%.[iii]		**$66,475,500**
	General Purpose Revenue	$29,226,900	
	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.[iii]	$26,194,900	
	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.[iv]	$2,968,800	
	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.[v]	$3,996,300	
	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.	$4,088,600	
Title IV-B, Subpart 2 (FFY2014)	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		**$5,085,300**

	share of children whose families receive supplemental nutrition assistance. The state must provide 25% match.[vi]		
	State-level adoption, promotion and support	$1,063,700	
	Training and technical assistance to counties and tribes	$238,300	
	ACE Study and Trauma Project	$189,600	
	Family support, preservation and reunification	$3,593,700	
Program	**Description**	**Amount**	**Total Amount**
Empowering Families of Milwaukee Home Visiting Program (2014 - 15)	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[vii]	$812,000	
Family Foundations Home Visiting Programs (2014 - 15)	Services focused on improving birth outcomes, supporting maternal and child health, enhancing family functioning, promoting safety and development, and preventing child abuse and neglect.[viii]		**$8,563,400**
	General Purpose Revenue	$985,700	
	Formula grant	$1,206,500	
	Competitive grant	$6,371,200	
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.[ix]		**$4,658,800**
	General Purpose Revenue	$1,729,900	
	Substance Abuse Block Grant	$1,707,100	
	Temporary Assistance to Needy Families	$577,500	
	Title V abstinence education grant	$644,300	
SAFE Milwaukee (2015)	This is a short-term, behaviorally oriented family therapy program targeted to youth ages 10 to 18 who have severe behavior challenges, are frequently and/or at resik of being delinquent. United Neighborhood Centers of Milwaukee (UMOS) facilities are located in the neighborhoods with the youth at highest risk of delinquencies.[x]		$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		$2,000,000

	services, in-home therapy, alcohol and drug assessment and treatment for parents, mental health services, respite care, transportation, and connection to community services.[xi] This is a five year waiver totaling $10,000,000 with $2,000,000 designated annually to provide flexible funding for reunifying families.		
Domestic Violence Services	Grants to local domestic violence service providers to assist victims of domestic violence. Services are provided to adults and children.		$5,572,769
Special Needs Adoption	Services provided include training to pre-adoptive homes, case management, and adoption studies[xii] for children with special needs for whom it is difficult to find an adoptive home.		$4,148,700
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.[xiii]		**$93,268,700**
	General Purpose Revenue	$47,929,100	
	Title IV-E (FED)	$45,339,600	
Adoption Resource Centers	Provides information on the adoptive process to prospective adoptive parents, birth parents, adoptive families, professionals, and the general public.[xiv]		$338,000
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 $70,000 and $98,500.[xv]		$ 500,000
Kinship Care (2014-15 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[xvi]		$20,340,400
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		$2,200,000

	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			
Child Abuse and Neglect Prevention Board (2014 - 15)	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.[xvii]			**$3,011,000**
	General Purpose Revenue		$997,900	
	Title II of the Child Abuse Prevention and Treatment Act (CAPTA) Federal Funding (FED)		$636,300	
	Program Revenue comes from the sale of duplicate birth certificates, services such as state mailings, special computer services, training programs, printed materials and publications.		$1,361,800	
	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			
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.[xviii]			**$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.[xix]			**$269,206,722**
	FY 2014 Federal CCDF (Discretionary, Mandatory and Matching)		$89,857,446	
	Federal TANF Transfer to CCDF		$62,899,870	

	Direct Federal TANF spending on Child Care		$100,000,000	
	State CCDF Maintenance of Effort Funds		$16,449,406	

[i] Austin, Sam and Gentry, John, *Community Aids/Children and Family Aids*, Informational Paper 47, Wisconsin Legislative Fiscal Bureau, January, 2015 p. 6
[ii] Gentry, John, *Child Welfare Services in Wisconsin*, Informational Paper 50, Wisconsin Legislative Fiscal Bureau, January, 2015 p. 26
[iii] Ibid p. 26 - 29
[iv] Ibid p. 29
[v] Ibid p. 31
[vi] Ibid p. 30
[vii] Ibid p. 44
[viii] Ibid p. 44
[ix] Ibid p. 45
[x] Ibid p. 46
[xi] Ibid p. 15
[xii] Ibid p. 18
[xiii] Ibid p. 20
[xiv] Ibid p. 21
[xv] Ibid p. 21
[xvi] Gentry, John D., Wisconsin Works (W-2) and Other Economic Support Programs, Informational Paper 44, Wisconsin Legislative Fiscal Bureau, January 2015, p. 43
[xvii] Ibid p. 40
[xviii] Steinschneider, Michael, Crime Victim and Witness Services, Informational Paper 60, Wisconsin Legislative Fiscal Bureau, January, 2015 P. 10
[xix] Gentry, John D., Wisconsin Works (W-2) and Other Economic Support Programs, Informational Paper 44, Wisconsin Legislative Fiscal Bureau, January, 2015 p. 77

Wisconsin Office of Children's Mental Health: Department of Corrections (DOC) Financial Table

Funding Title	Purpose	Amount	Total Amount
Juvenile Justice System			**$162,800,000**
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).[i]		$30,012,300
	Mendota Juvenile Treatment: DHS operates a 29-bed, secured mental health unit for male juveniles who have complex mental health issues.[ii]	$4,138,300	
	General Purpose Revenue $1,365,500		
	Program Revenue $2,772,800		
	Lincoln Hills School - average daily population (2013 - 14): 221	$21,556,900	
	Copper Lake School - average daily population (2013 - 14): 30	$4,317,100	
County Community Youth and Family Aids	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.		$91,039,500
	General Purpose Revenue	$88,600,000	
	Program Revenue: Federal funds received by the DHS and transferred to DOC for out-of-home care for eligible juveniles	$2,449,200	
	Alcohol and Other Drug Abuse Treatment Programs	$1,333,400	
Serious Juvenile Offenders	State funded. Average daily population (2013 - 14): 206		$14,500,000
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.[iii]		$4,200,000
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 2014: 10.[iv]		
Community Intervention Program	Early intervention services for first-time juvenile offenders and for community-based interventions for seriously chronic juvenile offenders.[v]		$3,700,000
Youth Diversion Program	Gang diversion programming from General Purpose Revenue, Program Revenue and Federal Funding.[vi]		$1,275,000
Utility Aid	State tax revenues used with county discretion.[vii]		$33,900,000
County and Municipal Aid	State tax revenues used with county discretion.[viii]		$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 (2014 – 15)	The state directly funds certain administrative costs.[ix]		$2,300,000
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.[x]		$238,000

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i Carmichael, Christina D., *Juvenile Justice and Youth Aids Program*, Informational Paper 56, Wisconsin Legislative Fiscal Bureau, January, 2015, p. 20.
ii Ibid, p. 19
iii Ibid, p. 26
iv Ibid, p. 19
v Ibid, p. 33
vi Ibid, p. 33
vii Ibid, p. 33
viii Ibid, p. 33
ix Ibid, p. 34
x Steinschneider, Michael, Crime Victim and Witness Services, Wisconsin Legislative Fiscal Bureau, January 2015.

Wisconsin Office of Children's Mental Health: Department of Health Services (DHS) Financial Table

Funding Title	Description	Amount	Total
Basic County Allocation (2014 - 15)	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.[i]		**$169,951,600**
	General Purpose Revenue	$138,665,200	
	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.[ii]	$20,031,800	
	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. [iii]	$11,254,600	
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.[iv]		**$27,005,484**
	Community Aids Allocation (20% Prevention)	$9,735,700	
	Women's Substance Abuse Treatment Initiatives[v]	$3,457,089	
	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, DMHSAS Operations/Administration		$2,144,700	
	WI Department of Corrections		$1,349,200	
	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 Substance Abuse Screening and other grants		$1,621,600	
	Other primary prevention initiatives		$2,082,916	
	Other treatment initiatives		$3,456,279	
Mental Health Block Grant (FFY 2013 - 14)	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.[vi]			**$7,379,800**
	Community Aids Allocation: Funds support a wide range of human services		$2,513,400	
	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		$1,015,800	
	NAMI			
	Wisconsin Family Ties			
	Independent Living Resources			
	Peer-run organizations			
	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		$530,800	

	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	$494,000	
	Training and Technical Assistance: training of mental health professionals	$160,000	
	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	
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:[vii] 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.		**$4,426,500**
	General Purpose Revenue	$2,500,000	
	Mental Health Block Grant	$ 1,826,500	
	Department of Children and Families	$100,000	
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.[viii]		**$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.[ix]		**$2,000,000**

	General Purpose Revenue	$500,000	
	Kubly Foundation $1,500,000		
Family Support Program (FSP)	DHS may distribute up to $5,089,800 GPR annually to counties. FSP supports children with severe disabilities to remain at home. The program serves families and children with physical, mental, or emotional impairments and substantial limitations in at least three of seven functions of daily living, including self-care, receptive and expressive language, learning, and mobility. FSP provides eligible families up to $3,000 a year in services and goods, such as training for parents in behavioral management, respite care, home modifications, and attendant care.[x]		**$4,909,300**
Birth to 3 Program (2013)	Serves children under 3 years of age who have developmental delays and disabilities[xi]		**$30,877,806**
	County Funds (includes community aids)	$15,880,876	
	State and Federal Funds	$11,273,513	
	Medicaid	$2,808,128	
	Parental Cost Share	$336,369	
	Private Insurance	$255,384	
	Other	$323,536	
Title V	Regional Centers for Children and Youth with Special Health Care Needs[xii]		**$1,218,526**

[i] Austin, Sam, and Gentry, John, *Community Aids/Children and Family Aids*, Informational Paper 47, Wisconsin Legislative Fiscal Bureau, January, 2015 p. 3.
[ii] Ibid, p.3
[iii] Ibid, p. 3
[iv] Ibid, p. 3
[v] Community Mental Health and Substance Abuse Prevention and Treatment Block Grant reporting from DHS-DMHSAS
[vi] Dyck, Jon, *Services for Persons with Mental Illness*, Informational Paper 49, Wisconsin Legislative Fiscal Bureau, January 2015, p. 9-11
[vii] Ibid p. 11-12
[viii] Ibid, p. 6
[ix] Ibid, p. 12
[x] Austin, Sam, and Gentry, John, *Community Aids/Children and Family Aids*, Informational Paper 47, Wisconsin Legislative Fiscal Bureau, January, 2015 p.4
[xi] Mabrey, Stephanie, Services for Persons with Developmental Disabilities, Information Paper 48, Wisconsin Legislative Fiscal Bureau, January 2015, p. 14
[xii] https://www.dhs.wisconsin.gov/mch/blockgrant/budget-narrative.pdf

Funding Title	Purpose	Amount
Grants to Local Educational Agencies (LEAs) – Elementary and Secondary Education Act (ESEA) - Title I	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.[i]	$208,521,570
School Improvement Programs – Title I	Four percent of the Title I allocation is reserved for school improvement activities.	$6,899,804
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.[ii]	$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.[iii]	$1,380,282
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.[iv]	$933,644
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 bBards (CCDEBs). The state reimburses a portion of the costs for educating and transporting pupils enrolled in special education, including school age parent programs.[v]	$368,939,100
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.[vi]	$3,500,000
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.[vii]	$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.[viii]	$126,975,000
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).[ix]	$109,184,500
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.[x]	$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.[xi]	$23,703,600
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.[xii]	$5,000,000
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.[xiii]	$13,453,300

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.[xiv]	$8,589,800
Tuition Payments	The state reimburses the cost of educating children who live where there is no parental property tax base support.[xv]	$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 (Green Bay, Kenosha, Merrill, Milwaukee, and West Bend) and three CESAs.[xvi]	$6,264,100
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.[xvii]	$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.[xviii]	$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.[xix]	$4,0670300
Career and Technical Education Incentive Grants	Funding provided to encourage high school programming that results in pupils earning certificates in industries or occupations identified as having worker shortages.[xx]	$3,000,000
School Breakfast	Funding is used to provide a per meal reimbursement of $0.15 for each breakfast served under the federal School Breakfast Program.[xxi]	$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.[xxii]	$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.[xxiii]	$1,350,000
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. These expenses are 100% reimbursable if funds are available.	$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.[xxiv]	$434,200
Aid for Cooperative Educational Service Agencies	Aid is provided for the administrative cost of each of the 12 CESAs. School districts match.[xxv]	$260,600
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.[xxvi]	$37,200
Supplemental Aid	Schools meeting criteria can apply to DPI for equalization aid. One school district participated in 2014 - 15.[xxvii]	$100,000
Aid for Transportation – Youth Options	Allows any 11th or 12th grade public school student to enroll in one or more nonsectarian courses at a postsecondary institution for high school or postsecondary credit. Funding for transportation for parents unable to afford the costs.[xxviii]	$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.[xxix]	$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.[xxx]	$1,284,700

[i] http://www2.ed.gov
[ii] Dpi.wi.gov/migrant
[iii] Dpi.wi.gov/neglected-delinquent
[iv] Dpi.wi.gov/homeless
[v] Kava, Russ and Pugh, Christa, *State Aid to School Districts*, Informational Paper 24, Wisconsin Legislative Fiscal Bureau, January 2015, p. 18
[vi] Ibid, p.19
[vii] Ibid, p. 20

[viii] Ibid, p. 20
[ix] Ibid, p. 22
[x] Ibid, p. 22
[xi] Ibid, p. 23
[xii] Ibid, p. 23
[xiii] Ibid, p. 23
[xiv] Ibid, p. 25
[xv] Ibid, p. 25
[xvi] Ibid, p. 26
[xvii] Ibid, p. 26
[xviii] Ibid, p. 26
[xix] Ibid, p. 20
[xx] Ibid, p. 27
[xxi] Ibid, p. 27
[xxii] Ibid, p. 27
[xxiii] Ibid, p. 28
[xxiv] Ibid, P. 28
[xxv] Ibid, p. 29
[xxvi] Ibid, p. 29
[xxvii] Ibid, p. 30
[xxviii] Ibid, p. 30
[xxix]Ibid, p. 30
[xxx] Ibid, p. 28

Wisconsin Office of Children's Mental Health: Discretionary Grants Financial Table

SAMHSA Grant Awards[i]	Amount	City	Program Period	Description
Dryhootch	$100,000/yr	Milwaukee	09/14 – 09/17	Provide peer support to veterans and their families
Appleton School District	$100,000/yr	Appleton	09/14 - 09/16	Certify 30 Youth Mental Health First Aid instructors; train 1,200 adults
Lac Du Flambeau Band of Chippewa	$290,078	Lac du Flambeau	09/14 -09/17	Expand substance abuse treatment capacity in Tribal Healing to Wellness Courts and Juvenile Drug Courts
Neenah Joint School District	$100,000/yr	Neenah	09/14 – 09/16	Focus on 12-18 year olds using adults trained in Youth Mental Health First Aid
United Community Center, Inc	$524,000/yr	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
Milwaukee Public Schools	$100,000/yr	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, Milw. 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.
Fond du Lac School District	$100,000/yr	Fond du Lac	09/14 - 09/16	Certify 8 trainers in Youth Mental Health First Aid; build on existing Mental Health Services Steering Committee
Wisconsin Family Ties	$100,000/yr	Madison	09/15 – 09/16	Develop statewide peer network for recovery and resiliency
Wisconsin Family Ties	$70,000/yr	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
County of Barron	$125,000/yr	Barron	09/09 – 09/19	Prevent and reduce youth substance use
Red Cliff Band of Lake Superior Chippewa	$399,998/yr	Bayfield	09/14 - 09/17	Provide system of care Maamawi (Together) Red Cliff Circles of Care Program
Edgerton Hospital and Health Services	$125,000/yr	Edgerton	09/09 – 09/19	Prevent and reduce youth substance use
Northeastern WI Area Health Ed Center	$125,000/yr	Manitowoc	09/14 – 09/19	Prevent and reduce youth substance use

Menominee of WI Indian Tribal Council	$195,859/yr	Keshena	09/14 - 09/19	Prevent youth suicide
Marshfield Clinic Research Foundation	$125,000/yr	Marshfield	09/14 – 09/19	Prevent and reduce youth substance use
Winnebago Co Health Dept.	$125,000/yr	Oshkosh	09/14 – 09/19	Prevent and reduce youth substance use
University of WI Eau Claire	$101,185/yr	Eau Claire	09/14 -09/17	Prevent suicide (Hope Inspires); provide info on mental health promotion and suicide prevention resources, class and speakers
City of Janesville	$125,000/yr	Janesville	09/15 – 09/18	Train 1.6% of the adult population in Mental Health First Aid
Wisconsin Dept. of Health Services – Project YES!	$1,037,360/yr	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
Wisconsin Dept. of Public Instruction – Project Aware	$1,950,000/yr	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
Wisconsin Dept. of Public Instruction – Safe Schools/Healthy Students	$2,214,000/yr	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
West Allis - Milwaukee	$125,000/yr	West Allis	09/09 – 09/19	Prevent and reduce youth substance use
Berlin Area School District	$100,000/yr	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
School Dist of McFarland	$95,256/yr	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
Arbor Place, Inc.	$125,000/yr	Menominee	09/15 – 09/18	Train 400 adults on Mental Health First Aid

Outreach Community Health Centers	$116,587/yr	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
Wauwatosa School District	$125,000/yr	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
Assistant Secretary for Planning and Evaluation Poverty Research Center	$1,299,680/yr	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.
Campus Suicide	$102,000/yr	Madison	08/12 -07/15	Implement campus/community Suicide Prevention Partnership Council; implement evidence-based practices to reach out to high risk populations
Statewide Family Network Grants	$70,000/yr	Madison	07/13 - 06/16	Transform children's mental health system; children to 18 and young adults to age 26
Statewide Peer Network for Recovery & Resiliency Grants	$100,000/yr	Madison	09/14 - 09/15	Strengthen the voices of mental health consumers
DHHS Office of Adolescent Health	**Amount**	**City**	**Program Period**	**Description**
Pregnancy Assistance Fund *State of Wisconsin - DPI*	$1,500,000/yr	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.
ACF Office of Family Assistance[ii]	**Amount**	**City**	**Program Period**	**Description**
Health Marriage and Responsible Fatherhood Grants/ New Pathways for Fathers and Families	$2,000,000	Milwaukee	10/15 – 9/20	Encourage fathers to be present in their children's lives
ACF Grant Awards[iii]	**Amount**	**City**	**Program Period**	**Description**
Early Head Start- Child Care Partnerships	$1,400,000	Ladysmith		Enhance and support early learning settings; provide new, full-day comprehensive services that meet the needs of working families and

Indianhead Community Action Agency				prepare children for the transition into preschool
Early Head Start- Child Care Partnerships *Dane Cty Parent Council, Inc.*	$1,000,000	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
Early Head Start- Child Care Partnerships *Acelero, Inc.*	$1,200,000	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
Early Head Start- Child Care Partnerships *Next Door Foundation*	$4,800,000	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
Native Languages – Preservation and Maintenance *Red Cliff Band of Lake Superior*	$272,057/yr	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
State Personal Responsibility Education Program (PREP)	$932,700	Madison	2015	Educate young people on abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS
Title V State Abstinence Grant	$711,597	Madison	2015	Educate youth on abstinence, provide mentoring and counseling targeting youth in the foster care system and who are homeless
HRSA Maternal Child Health[iv]	**Amount**	**City**	**Program Period**	**Description**
Early Childhood Comprehensive Systems Grant	$140,000/yr	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
Eliminating Disparities in Perinatal Health *Great Lakes Inter-Tribal Council, Inc.*	$750,000/yr	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
Wisconsin Pediatric Medical	$300,000/yr	Madison	09/14 – 08/17	Provide children and youth with special health care needs with

Home				integrated care through family centered medical homes
Wisconsin Maternal Child Health Lead Program	$803,569/yr	Madison	07/1989 – 6/2016	Provide education in leadership, clinical practice, research, public health systems and policy to interdisciplinary MCH trainees
Department of Education[v]	**Amount**	**City**	**Program Period**	**Description**
Bringing Evidence Based Practices to Practitioners in Wisconsin	$5,242,866	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
Race to the Top Early Learning Challenge	$34,052,084	Madison	1/13 – 12/16	Focus on improving young children's early learning and programming
School Climate Transformation Grants *Berlin Area Schools*	$231,489	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[vi]
School Climate Transformation Grants *Appleton Area Schools*	$660,354/yr	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
School Climate Transformation Grants *Wausau School District*	$747,030/yr	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
School Climate Transformation Grants *State of Wisconsin - DPI*	$578,521/yr	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[vii]
Project Prevent Grants	$459,586/yr	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.[viii]
School Emergency Management Grants	$472,509	Madison	2014 – 2015	Expand the capacity to assist school districts in developing and implementing high-quality school emergency operations plans[ix]

State of Wisconsin – DPI				
National Institute of Justice[x]	**Amount**	**City**	**Program Period**	**Description**
Wisconsin School Violence and Bullying Prevention Study *State of Wisconsin - DPI*	$858,187	Madison	2015 - 2018	Examine the impact of Positive Behavioral Interventions and Supports in combination with a comprehensive bullying prevention program in middle schools

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i www.samhsa.gov/grants-awards-by-state/details/Wisconsin
ii https://www.acf.hhs.gov/sites/default/files/ofa/hmrf_2015_grant_awards.pdf
iii http://www.acf.hhs.gov/programs/ecd/early-learning/ehs-cc-partnerships/grant-awardees
iv https://mchdata.hrsa.gov/dgisreports/Abstract/AbstractSummary.aspx?tbKeyword=Wisconsin&rbKeyword=Exact&SearchKeywordsOnly=Search
v http://findit.ed.gov/search?utf8=%E2%9C%93&affiliate=ed.gov&query=Wisconsin
vi http://www.ed.gov/news/press-releases/us-department-education-invests-more-70-million-improve-school-climate-and-keep-students-safe
vii Ibid
viii http://www2.ed.gov/programs/projectprevent/2014awards.html
ix http://www.ed.gov/news/press-releases/us-department-education-invests-more-70-million-improve-school-climate-and-keep-students-safe
x http://www.nij.gov/funding/awards/Pages/2015.aspx

Wisconsin Office of Children's Mental Health: 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 who provide integrated services to families.[i]		**$1,990,579**
	General Purpose Revenue	$1,271,879	
	Title IV-B sub-part 2	$408,700	
	Federal Community Services Block Grant	$310,000	
	Funding can be used for domestic abuse, child welfare, self-sufficiency, teen parenting, childcare		
	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.		
DPI Allocation	Tribal Language Revitalization Grants - PR Funded These grants are funded from tribal gaming program revenue transferred from DOA[ii]		**$222,800**

[i] Austin, Sam and Gentry, John, *Community Aids/Children and Family Aids*, Wisconsin Legislative Fiscal Bureau, January 2015, p. 7

[ii] Kava, Russ and Pugh, Christa, *State Aid to School Districts*, Informational Paper 24, Wisconsin Legislative Fiscal Bureau, January 2015, p. 29.

Children's Mental Health Collective Impact Stakeholders' Identify Activities to Promote Socially and Emotionally Healthy Children and Families

The Children's Mental Health Collective Impact (CMHCI) stakeholders believe that children should grow up in safe, nurturing, and supportive homes within thriving communities where they are surrounded by positive relationships with peers and caring adults. Additionally, the group believes that children need to play and learn and to have a sense of meaning and purpose in their lives. Physical well-being is also needed as engaging in regular physical activity and receiving adequate nutrition further builds a healthy foundation.[1] Unfortunately, these expectations are often thwarted by the experiences of trauma, maltreatment and other adverse childhood experiences. For these reasons, the CMHCI stakeholders are in the process of identifying concrete ways to improve the lives of Wisconsin families by promoting strategies that will **decrease toxic stress**, **promote resilience,** and ensure **access to support and services** for children and families in need.

The following ideas are under development but serve as a starting point. In 2016, CMHCI stakeholders will continue refine the activities listed below, further populate the list, and enhance and add measurable outcomes.

Decrease Toxic Stress

Exposure to toxic stress or Adverse Childhood Experiences (ACEs) can have profound and lasting consequences on a child's physical and mental health.[2] In addition to experiences listed on the ACE survey,[3] the CMHCI stakeholders recognize the impact of experiences outside this list such as poverty, racism, and community violence. For this reason, the stakeholders believe that addressing the following factors will improve the social and emotional well-being of Wisconsin's children by reducing their exposure to toxic stress:

- Reduce unemployment and create job opportunities that raise families out of poverty
- Reduce homelessness
- Create safe housing options
- Reduce community and gun violence
- Reduce child abuse and neglect
- Reduce racism
- Eliminate children's exposure to toxic substances such as lead

Measurements:

- ✓ Percent reduction of unemployment
- ✓ Percent reduction of the number of families with children eight years old and under living in poverty
- ✓ Percent reduction of homeless families
- ✓ Percent reduction in violent crimes
- ✓ Percent reduction in gun violence

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[1] Robert Wood Johnson Foundation (2014). *Are the Children Well? A Model and Recommendations for Promoting the Mental Wellness of the Nation's Young People.* Prepared by Child Trends.

[2] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition. Retrieved from www.developingchild.harvard.edu.

[3] Learn more about the ACE survey by visiting this website: http://acestoohigh.com/got-your-ace-score/

- ✓ Percent reduction of substantiated child abuse and neglect reports
- ✓ Percent reduction in racial disparities across all child and family-serving systems
- ✓ Percent reduction in children's exposure to lead

Promote Resilience

While toxic stress can have negative effects on children's development, protective factors can increase children's resilience. Providing support to parents is one of the best ways to enhance a child's resilience and subsequently the child's life outcomes.[4] Research also shows that a child's community can affect his or her mental and physical health;[5] thus, the importance of ensuring that all adults are able to model healthy behaviors and coping skills. The CMHCI identified the following resilience-building activities:

Policy

- Apply Wisconsin's 2013 Senate Joint Resolution 59[6] to all policy related to children and families
- Provide paid family leave through employee-paid payroll taxes as is done in California, New Jersey, and Rhode Island[7]
- Limit classroom sizes
- Require parent involvement and leadership in all state agencies' policy development related to children and families

  Measurements:
  - ✓ Percent of bills with a Joint Resolution 59 analysis performed by the Legislative Reference Bureau
  - ✓ Percent of employers who provide paid time off
  - ✓ Percent of schools that prioritize small classroom size
  - ✓ Percent increase of parent participation in policy development at each of the family-serving state agencies

Prevention and Early Intervention

- Screen for parental depression during pediatric visits, during meetings with county nurse programs, and at Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) sites
- Mandate strength-based social and emotional development screenings as part of pediatric visits
- Increase access to high-quality child care and early childhood education, particularly for low-income families
- Provide children and families with access to healthy foods and opportunities for exercise
- Provide mindfulness-based stress reduction techniques in early education, schools and the workplace
- Offer pregnant mothers and expectant fathers ACE surveys and educational materials regarding the impact of toxic stress and the importance of resilience
- Support public health campaigns focused on ACE awareness, resilience and developing social and emotional well-being including how to increase child and family protective factors

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[4] Emde, R., and Robinson, J. Guiding principles for a theory of early intervention: A developmental-psychoanalytic perspective. In *Handbook of early childhood intervention*. 2nd ed. JP Schonkoff and S.J. Meisels, eds.
[5] Selected bibliographies available through the CDC Healthy Places webpage
[6] http://docs.legis.wisconsin.gov/2013/related/proposals/sjr59
[7] http://www.ncsl.org/research/labor-and-employment/paid-family-leave-resources.aspx

Measurements:

- ✓ Percent increase of parents who receive an annual depression screen
- ✓ Percent increase in the number of screens that use strength-based language
- ✓ Percent increase in the number of screenings for children's social and emotional development
- ✓ Percent increase in referrals to community supports and services as follow up to screening
- ✓ Percent of children living below 180% of the poverty line in 3 or more star settings
- ✓ Percent of schools and workplaces implementing mindfulness-based techniques
- ✓ Percent of parents receiving ACE information during pediatric visits

Training, Consultation and Support

- Provide information and ongoing training (Continuing Education Credits when appropriate) on brain development, the impact of trauma and the importance of healthy social and emotional development to every professional who touches the life of a child
- Create trauma-informed care (TIC) professional agency accreditation and rating system
- Infuse TIC, ACE information, and information related to social and emotional development into grade school, middle school and high school education curriculum
- Provide Crisis Intervention Training (CIT) to law enforcement, emergency responders, and correctional staff

Measurements:

- ✓ Percent of providers and legislators who receive training
- ✓ Percent of agencies and/or professionals with TIC accreditation
- ✓ Number of child serving agencies involved in TIC transformation
- ✓ Percent of law enforcement, emergency responders, and correctional staff trained in CIT

Provide Access to the Right Services and Supports at the Right Time

Rounding out the focus on reducing toxic stress and increasing resilience is the need to provide effective services and support to children and families with mental health issues. Wisconsin is building a more responsive, comprehensive service array for children with mental health needs which includes the creation of the Child Psychiatry Consultation Program, expansion of Coordinated Services Teams Initiatives and Comprehensive Community Services, development of a regional consortium to create a model for delivering mental health services in rural areas and expansion of in-home counseling services for children as well as the certification of Parent Peer Specialists. CMHCI recommendations in this domain include the following:

County Services

- Provide a 'no-wrong-door approach' to families seeking county services
- Ensure that people in every county have access to the same array of mental health services including evidence-based practices
- Provide parents and caregivers engaged in public services the option of working with Parent Peer Specialists
- Provide planned respite for children and families as a diversion from residential and inpatient hospitalizations

Measurements:

- ✓ Percent increase of providers who have integrated medical and behavioral health care
- ✓ Percent of counties that offer established service array

- ✓ Percent of services that include Parent Peer Specialists in their service array
- ✓ Percent increase of planned respite for families to reduce hospitalizations, and to provide gradual re-entry from the hospital back into community

Policy

- Require private insurers to provide mental health coverage on par with physical health coverage[8]
- Provide all children with medical homes to promote the integration of physical and behavioral health
- Expand the Child Psychiatry Consultation Program
- Provide competitive Medicaid reimbursement
- Redesign the Medicaid Prior Authorization process to maximize efficiency and eliminate unnecessary red tape

Resource Allocation, Development, Monitoring and Technical Assistance

- Create blended funding strategy across state agencies to support children's social and emotional development
- Shift resources from deep-end services (e.g., hospitalizations and residential care) to improving prevention and early intervention
- Commit resources to data integration across all child and family-serving systems
- Monitor and coach counties to ensure that all Coordinated Service Teams operate with fidelity
- Require programs receiving public funding to report child and family outcomes
- Create and maintain a website of mental health clinicians trained in evidence-based practices
- Design a children's mental health consultation infrastructure to be accessed by all child and family-serving systems

Measurements:

- ✓ Number of funders participating in collective impact and/or blended funding strategies
- ✓ Percent of general state revenue and county dollars invested in early intervention or prevention
- ✓ Percent reduction of youth psychiatric hospitalizations
- ✓ Percent of money used for expanding crisis services
- ✓ Percent reduction at Winnebago Mental Health Institute (WMHI)
- ✓ Percent increase of counties/regions signing memoranda of understandings linking Coordinated Services Teams Initiatives and Comprehensive Community Services to ensure consistency of care, particularly related to children's crisis plans
- ✓ Number of state and county contracts that include language outlining that reimbursement will be based on reporting outcomes and demonstrating progress
- ✓ Percent increase in the sites receiving mental health consultation, training and coaching

[8] See National Conference of State Legislatures for more information http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx

Appendix C-4: Missouri Model for Trauma-Informed Care Implementation

The Missouri Model: A Developmental Framework for Trauma-Informed

The implementation of a trauma-informed approach is an ongoing organizational change process. A "trauma-informed approach" is not a program model that can be implemented and then simply monitored by a fidelity checklist. Rather, it is a profound paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time. Some leaders in the field are beginning to talk about a "continuum" of implementation, where organizations move through stages. The continuum begins with becoming trauma aware and moves to trauma sensitive to responsive to being fully trauma-informed.

Purpose: To ensure that agencies do no harm; to assess the implementation of basic principle of trauma-informed approaches in various organizational settings; to develop a common language and framework for discussion; and to help increase the effectiveness of services, wherever and whatever they are, by increasing awareness of trauma.

Application: To a very wide range of settings, including but not limited to behavioral health services.

Use:

- Not for formal evaluation or certification, but for informational purposes
- To help anyone who is interested (clients, advocates, other agencies, etc.) determine whether a particular agency or setting is meeting basic criteria for integration of trauma principles
- To help agencies identify where they are on the continuum and where they want to be. Organizations can choose the appropriate place on the continuum based on their needs and setting.

This document was developed by a group of Missouri organizations, MO State Trauma Roundtable, that have been active champions in addressing the impact of trauma and working towards becoming trauma-informed organizations. They represent a variety of organizations that serve children, youth, families and adults in a variety of settings including healthcare, inpatient psychiatric, substance use disorder, and community based mental health services. Anyone is free to use this document but would appreciate notification of such to patsy.carter@dmh.mo.gov. The recommended citation when used is *Missouri Model: A Developmental Framework for Trauma-informed, MO Dept. of Mental Health and Partners (2014).*

Trauma Aware

Definition	Processes	Indicators	Resources
Key Task: Awareness and attitudes **Trauma aware** organizations have become aware of how prevalent trauma is and have begun to consider that it might impact their clientele and staff.	Leadership understands that knowledge about trauma could potentially enhance their ability to fulfill their mission and begins to seek out additional information on the prevalence of trauma for the population served. Awareness training is offered (including definitions, causes, prevalence, impact, values and terminology of trauma-informed care.) People are made aware of how and where to find additional information, and are supported in further learning. The organization explores what this new information might mean for them and what next steps may need to be taken.	Most staff: 1) Increase in understanding the concept of trauma 2) Increase in understanding of how the impact of trauma can change the way they see (and interact with) others. The impact of trauma is referenced in informal conversations among staff.	**Websites:** National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/ National Center on Domestic Violence, Trauma and Mental Health (trauma-aware) http://www.nationalcenterdvtraumamh.org/The Anna Institutehttp://www.theannainstitute.org/ National Center for PTSD, U.S Department of Veterans Affairs http://www.ptsd.va.gov/ Resource Center on Violence Towards Women http://www.vawnet.org/news/2013/04/trauma-informed/ ACE Study www.cdc.gov/violenceprevention/acestudy/ http://acestudy.org/home http://acestoohigh.com/resources/ http://www.acesconnection.com/ **Documents:** SAMHSA's TIP 57: Trauma-informed Care in Behavioral Health Services– Chapter 2 Trauma Awareness. http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf SAMHSA concept paper (trauma-aware) http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf Paul Tough. The Poverty Clinic. The New Yorker, March 21, 2011.

Trauma Sensitive

Definition	Processes	Indicators	Resources
Key Task: Knowledge, application, and skill development **Trauma sensitive** organizations have begun to: 1) explore the principles of trauma-informed care (safety, choice, collaboration, trustworthiness, and empowerment) within their environment and daily work; 2) build consensus around the principles; 3) consider the implications of adopting the principles within the organization; and 4) prepare for change.	Values of a trauma-informed approach are processed with staff. Through a self-assessment process, the organization identifies existing strengths, resources and barriers to change as well as practices that are consistent or inconsistent with trauma-informed care. Leadership prepares the organization for change and leads a process of reflection to determine readiness for change. The organization begins to identify internal trauma champions and finds ways to hire people who reflect in their attitudes and behavior alignment with the trauma-informed principles.	The organization values and prioritizes the trauma lens; a shift in perspective happens. Trauma is identified in the mission statement or other policy documents. Trauma training for all staff is institutionalized, including within new staff orientation. Basic information on trauma is available and visible to both clients and staff, through posters, flyers, handouts, Web sites, etc. Direct care workers begin to seek out opportunities to learn new trauma skills. Management recognizes and	**Websites**: NCTSN http://www.nctsn.org/ National Center on Trauma-informed Care www.nasmhpd.org/TA/nctic.aspx Child Trauma Academy http://childtrauma.org/ International Society for Traumatic Stress Studies **Toolkits and Videos**: Healing Neen (DVD) http://healingneen.com/ Fallot and Harris Organization Self Assessment Tool http://www.theannainstitute.org/TIPSASCORESHEET.pdf Risking Connection organizational assessment http://www.traumainformedresponse.com/uploads/Sec_03-TReSIA-Assessment.pdf Institute for Health and Recovery http://healthrecovery.org/images/products/30_inside.pdf **Documents**: SAMHSA's TIP 57: Trauma-informed Care in Behavioral Health Services, 2014. Ann Jennings and Ruth Ralph. In Their Own Words, 2007. www.theannainstitute.org/ITOW.pdf A Long Journey Home: A Guide for Creating Trauma–Informed Services for Mothers and Children Experiencing Homelessness

	The organization examines its commitment to consumer involvement and what next steps could be taken. The organization begins to review tools and processes for universal screening of trauma. The organization begins to identify potential resources for trauma specific treatment.	responds to compassion fatigue and vicarious trauma in staff.	http://www.familyhomelessness.org/media/89.pdf Trauma-sensitive schools http://traumasensitiveschools.org

Trauma Responsive

Definition	Processes	Indicators	Resources
Key Task: Change and integration **Trauma responsive** organizations have begun to change their organizational culture to highlight the role of trauma. At all levels of the organization, staff begins re-thinking the routines and infrastructure of the organization.	Planning and taking action. Begin integration of principles into staff behaviors and practices. Begin integration of principles into staff supports: • Addressing staff trauma • Self-care • Supervision models • Staff development • Staff performance evaluations Begin integration of principles into organizational structures: • Environmental review • Record-keeping revised • Policies and procedures re-examined • Self-help and peer advocacy incorporated	Staff applies new knowledge about trauma to their specific work. Language is introduced throughout the organization that supports safety, choice, collaboration, trustworthiness and empowerment. The organization has policies that support addressing staff's initial and secondary trauma. All clients are screened for trauma and/or a "universal precautions" approach is used. People with lived experience are engaged to play meaningful roles throughout the agency (employees, board members, volunteers, etc.)	**Website:** National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/ **Documents:** SAMHSA's TIP 57: Trauma-informed Care in Behavioral Health Services http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf Healing the Hurt – Rich et al (men of color) http://www.dcf.state.fl.us/programs/samh/docs/Healing-the-Hurt.pdf Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others, van Dernoot, Lipsky & Burk, http://traumastewardship.com/ Engaging Women In Trauma-informed Peer Support: A Guidebook http://www.nasmhpd.org/docs/publications/EngagingWomen/PeerEngagementGuide_Color_UP_FRONT_PAGES.pdf Assaulted Staff Action Program http://americanmentalhealthfoundation.org/2012/04/the-assaulted-staff-action-program-asap-psychological-counseling-for-victims-of-violence/ **Training:** Child Welfare Trauma Toolkit (NCTSN) http://nctsn.org/products/child-welfare-trauma-training-

		Changes to environments are made. Trauma-specific assessment and treatment models are available for those who need them (either directly or through a referral process). Organization has a ready response for crisis management that reflects trauma-informed values.	toolkit-2008 Juvenile Detention Trauma Toolkit "Think Trauma" NCTSN http://learn.nctsn.org/enrol/index.php?id=92 Educators' Toolkit –NCTSN http://www.nctsn.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf Partnering with Youth and Families Toolkit (NCTSN) http://www.nctsn.org/nctsn_assets/pdfs/Pathways_ver_finished.pdf Psychological First Aid http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic, Lanius, Vermetten & Pain (Eds) http://www.cambridge.org/us/academic/subjects/medicine/mental-health-psychiatry-and-clinical-psychology/impact-early-life-trauma-health-and-disease-hidden-epidemic?format=HB **Best Practices websites:** Veterans Administration http://www.ptsd.va.gov/professional/pilots-database/index.asp NCTSN http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices NREPP (trauma) http://www.nrepp.samhsa.gov/ California Evidenced Based Clearinghouse for Child Welfare http://www.cebc4cw.org/

Trauma-Informed

Definition	Processes	Indicators	Resources
Key Task: Leadership **Trauma-informed** organizations have made trauma-responsive practices the organizational norm. The trauma model has become so accepted and so thoroughly embedded that it no longer depends on a few leaders. The organization works with other partners to strengthen collaboration	Measuring impact on clients Revision of policies and procedures Implementation of the agency's model/values is measured for fidelity to a trauma-informed model and appropriate corrective actions taken. Practice patterns of staff Program assessments Interventions to address the impact of secondary trauma on staff is monitored	Leadership including hiring of new leaders demonstrates a commitment to trauma-informed values (safety, choice, collaboration, trustworthiness and empowerment). All staff is skilled in using trauma-informed practices, whether they work directly with clients or with other staff. All aspects of the organization have been reviewed and revised to reflect a trauma approach. People outside	**Websites**: National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/Healthcaretoolbox.org https://www.healthcaretoolbox.org/ National Technical Assistance Center for Children's Mental Health http://gucchdtacenter.georgetown.edu/TraumaInformedCare/ Anna Institute video -Important Souls http://www.theannainstitute.org/a-bio.html Children, violence and trauma video https://www.youtube.com/watch?v=z8vZxDa2KPM Men and boys as sexual abuse survivors https://www.youtube.com/watch?v=Wx-JqBdwdAA **Documents**: SAMHSA's TIP 57: Trauma-informed Care in Behavioral Health Organizationshttp://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf Trauma-informed Supervision Guide – Institute for Health and Recovery http://healthrecovery.org/publications/detail.php?p=30 How Schools Can Help Students Recover from Traumatic Experiences – Rand Gulf State Policy Institute http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf Helping Traumatized Children Learn –Massachusetts Advocates for Children in Association with Harvard Law School http://traumasensitiveschools.org/ **Toolkits:** Trauma-informed Organizational Toolkit for Homeless National Center on Family Homelessness

around being trauma-informed.	Focus on reduction of stigma of trauma Human resource policies support hiring staff with knowledge and expertise in trauma The organization and staff become advocates and champions of trauma within their community Advocacy at a macro level with payers and policy-makers for systemic changes that support trauma-informed approaches	the agency (from the Board to the community) understand the organization's mission to be trauma-related. People from other agencies and from the community routinely turn to the organization for expertise and leadership in trauma-informed care. The organization uses data to inform decision making at all levels. A variety of sustainable training is promoted and made accessible to staff, including at new	http://www.familyhomelessness.org/media/90.pdf **Working with Partners:** Trauma-informed community building manual http://bridgehousing.com/PDFs/TICB.Paper5.14.pdf Collective Impact http://www.ssireview.org/articles/entry/collective_impact Creating Culture: Promising Practices of Successful Movement Networks https://nonprofitquarterly.org/governancevoice/23439-creating-culture-promising-practices-of-successful-movement-networks.html Prevention Institute – Cross Sector Collaboration http://www.preventioninstitute.org/ **Disaster Preparedness and Response:** SAMHSA's disaster TA center http://beta.samhsa.gov/dtac Public Health Emergency http://www.phe.gov/Preparedness/planning/abc/Pages/homeless-trauma-informed.aspx U.S. Department of Health and Human Services Office, Disaster Response for Homeless Individuals and Families: A Trauma-Informed Approach http://www.phe.gov/Preparedness/planning/abc/Documents/homeless-trauma-informed.pdf

		staff orientation. Ongoing coaching and consultation is available to staff on-site and in real time. The business model including fiscal structures works to meet the need to address trauma.	

Appendix C-5: TIC and EBP County and Tribal Activity Table

Wisconsin Office of Children's Mental Health (OCMH) Trauma-Informed Care (TIC) and Evidence-Based Practices (EBP) Summary Document, 2015

The OCMH created the following table in response to requests for information made by several stakeholder groups. These results originated from a Select Survey that was first posted on the Wisconsin TIC Listserv in October 2015. The four question survey was re-issued directly to county human service directors and tribal leaders by the Wisconsin County Association Human Service Association, the Department of Health Services Tribal Affairs Office, and the OCMH.

The first column represents the counties or tribes responses to the question: "Does your human services department have any organized, structured trauma-informed care culture change efforts underway?" The second column identifies the method chosen to facilitate the TIC transformation. The third column is a response to the following question: "Is there a concerted effort to train your area mental health/substance use providers in an evidence-based therapy?" The fourth column documents the EBPs being used. The final column identifies the county or tribe as well as the source of their responses. Finally, a key to the acronyms is located at the end of the document.

TIC	Which approach to TIC culture change are you using?	EBPs	Which evidence-based approaches are you using?	County or Tribe
1. No		No		Ashland (SM)
2. NR				**Bad River**
3. No		No		Bayfield (SM)
4. No		Yes	MFT	Buffalo (SM)
5. No		Yes	TF-CBT	Burnett (LS)
6. No		Yes	TF-CBT, CPP, MST, FFT	Calumet (LS)
7. No		No		Chippewa (SM)
8. NR				Clark
9. No		Yes	TF-CBT	Crawford (SM)
10. No		Yes	TF-CBT, EMDR, CBITS, MST, CPP, Target	Dane County (SM)
11. No		Yes	TF-CBT, MDFT, FAST	Dodge (SM)
12. No		No		Douglas (SM)
13. No		No		Dunn (SM)
14. No		Yes	TREM	Eau Claire (SM)
15. No		No		Florence (SM)
16. No	Plan to coordinate a three county training	No		Forest-Oneida-Vilas (SM)
17. No		Yes	TF-CBT, CPP, CBITS	**Forest Potawatomi (LS)**
18. No		Yes	TF-CBT	Green (SM)
19. No		No		Green Lake (LS)
20. No		Yes	EMDR	Iron (SM)

21. No		Yes	TF-CBT, EMDR	Jackson (LS)
22. No		No		Juneau (LS)
23. No	CST is offering TIC training	No		Kewaunee (SM)
24. NR				**Lac Court Oreilles**
25. NR				**Lac De Flambeau**
26. No	Plan to use our own approach	No		Lincoln (SM)
27. No		No		Manitowoc (SM)
28. No		No		Marathon (SM)
29. NR				Marinette
30. No		No		Marquette (SM)
31. No		Yes	TF-CBT	Monroe (SM)
32. No		Yes	TF-CBT, CPP, MST	Oconto (SM)
33. No		No		Oneida County
34. NR				**Oneida Tribe**
35. No	Plans to use Waupaca, SaintA and consultants	Yes	DBT	Ozaukee (SM)
36. No		Yes	TF-CBT, EMDR, MST (contracted)	Pepin (SM)
37. No		No		Pierce (LS)
38. No		Yes	TF-CBT	Portage (SM)
39. No		No	Starting process of identifying providers	Price (SM)
40. NR				**Red Cliff**
41. No		Yes	CBITS, MFT	Rusk (SM)
42. No		No		Sawyer(SM)
43. NR				**Sokaogon**
44. NR				**St. Croix**
45. No	Applying for WTP	Yes	TF-CBT, DBT, MST, CPP	St. Croix (SM)
46. No		Yes	TF-CBT	**Stockbridge-Munsee (LS)**
47. No		Yes	TF-CBT	Taylor (LS)
48. No		No		Trempealeau (SM)
49. No		Yes	TF-CBT, FAST	Vernon (SM)
50. No	Working on our environment/practice	Yes	TF-CBT	Washburn (SM)
51. No		Yes	Motivational Interviewing	Washington (LS)
52. No	Applying for WTP		TF-CBT, FFT, CPP, MST	Waushara (SM)
53. Yes	Consultant	Yes	TF-CBT, CPP, FSAT	Adams (LS)

54. Yes	Our own approach	Yes	TF-CBT	Barron (SM)
55. Yes	HHS, United Way, UWGB and community partners	No		Brown (SM)
56. Yes	Our own approach	No		Columbia (LS)
57. Yes	Consultant, own approach	Yes	TF-CBT, TI-CPP	Door (SM)
58. Yes	Sanctuary Model	Yes	TF-CBT	Fond du Lac (SM)
59. Yes	WTP	Yes	TF-CBT	Grant (SM)
60. Yes	Our own approach	Yes	TF-CBT	**Ho-Chunk Nation (LS)**
61. Yes	WTP - our own	Yes	TF-CBT	Iowa (SM)
62. Yes	NCTSN-courts	Yes	TF-CBT, Seeking Safety, Coping Cat, DBT, FFT, Incredible Years	Jefferson (LS)
63. Yes	WTP - our own	Yes	TF-CBT	Kenosha (SM)
64. Yes	NCTSN, SaintA	Yes	TF-CBT, CPP	La Crosse (LS)
65. Yes	Our own approach	Yes	TF-CBT	Lafayette (SM)
66. Yes	Our own approach	No		Langlade (SM)
67. Yes	SaintA, Fostering Futures, Safe Schools/Healthy Students, ACE Interface	Yes	TF-CBT	**Menominee Nation** and Menominee (SM)
68. Yes	SaintA	Yes	TF-CBT, EMDR, MST, FFT, DBT, PCIT, CBT	Milwaukee (SM)
69. Yes	WTP and our own approach	Yes	TF-CBT, DBT, FFT	Outagamie (LS)
70. Yes	Our own approach	Yes	TF-CBT, EMDR, MFT	Polk (SM)
71. Yes	SaintA	Yes	TF-CBT	Racine (LS)
72. Yes	Consultant	No		Richland (LS)
73. Yes	WTP	Yes	TF-CBT, EMDR, FFT	Rock (LS)
74. Yes	Our own approach	Yes	TF-CBT, FFT	Sauk (SM)
75. Yes	Consultant	No		Shawano (LS)
76. Yes	TBD. ACE Interface and additional consultation	Yes	EMDR, DBT, TF-CBT in planning	Sheboygan (SM)
77. Yes	Our own approach	Yes	TF-CBT, CPP, FFT	Walworth (SM)
78. Yes	Saint A's	No		Waukesha (LS)
79. Yes	Our own approach	Yes	TF-CBT, CPP	Waupaca (LS)
80. Yes	NCTSN	Yes	TF-CBT, MST, FAST, FFT	Winnebago (LS)
81. Yes	Our own approach	No		Wood (LS)

NR=No Response

LS=Info from Listserve

SM=Info from Survey Monkey

Counties that did not respond:
1. Clark
2. Marinette

Tribes that did not respond:
1. Bad River Band of Lake Superior Chippewa
2. Lac Court Oreilles Band of Lake Superior Chippewa
3. Lac De Flambeau Band of Lake Superior Chippewa
4. Oneida Nation of WI
5. Red Cliff Band of Lake Superior Chippewa
6. Sokaogon Chippewa Community
7. St. Croix Chippewa Indians of WI

Acronyms related to TIC approaches

ACE Interface= http://www.sainta.org/trauma-informed-care/wisconsin-ace-interface-project/
Fostering Futures= http://www.fosteringfutureswisconsin.org/
NCTSN=National Child Traumatic Stress Network http://nctsn.org/
SaintA=7 essential ingredients http://www.sainta.org/trauma-informed-care/seven-essential-ingredients/
WTP=WI Trauma Project (sponsored by the Dept. of Child and Family Services and informed by NCTSN)
http://docs.legis.wisconsin.gov/misc/lc/study/2014/1197/030_september_9_2014_meeting_10_15_a_m_412_east/sep09presentation_dcf_trauma_project

Acronyms related to EPBs

TF-CBT=Trauma-Focused Cognitive Behavioral Therapy
CPP=Child Parent Psychotherapy
MDFT=Multidimensional Family Therapy
TREM=Trauma Recovery and Empowerment Model
FAST=Families and Schools Together
EMDR=Eye Movement Desensitization Reprocessing
CBITS=Cognitive Behavioral Intervention for Trauma in the Schools
DBT=Dialectical Behavioral Therapy
MST=Multisystemic Therapy
FFT=Family Functional Therapy
PCIT=Parent Child Interaction Therapy
CC= Coping Cat

Descriptions can be found at: http://www.nrepp.samhsa.gov/Viewintervention.aspx?id=16

Wisconsin Office of Children's Mental Health: System Collaborations

The following table represents a point-in-time (November 2015) list of state agencies collaborative activities focused on improving the lives of children and families. The colors represent the activities designation within a public health conceptual framework;[1] specifically, green represents a universal approach, peach represents a secondary approach and lavender represents a tertiary approach.

The state agency acronyms are as follows:

CANPB=Child Abuse and Prevention Board
DCF=Department of Children and Families
DHS=Department of Health Services
DOC=Department of Corrections
DPI=Department of Public Instruction
DWD=Department of Workforce Development
OCMH=Office of Children's Mental Health
WEDC=Wisconsin Economic Development Corporation.

Project/Initiative	Description
Brighter Futures Lead: DCF (DHS)	• Prevent and reduce violence, substance use, child abuse and neglect, and adolescent pregnancies Counties include: Barron, Dane, Kenosha, Outagamie, Portage, Kenosha, Washington, Red Cliff Band of Lake Superior Chippewa Ongoing
Connections Count Lead DCF (Fostering Futures' Policy Advisory Council)	• Connect vulnerable families (with children aged 0-5) to resources; connections made through the assistance of a trusted community member 2016-2017
Family Foundations Home Visiting Lead: DCF (CANPB, DHS, DPI, OCMH)	• Provide support to families from pregnancy to 8 years old with focus on parenting, school readiness, health and preventing child abuse and neglect Ongoing

[1] A Public Health Approach to Children's Mental Health: A Conceptual Framework http://mentalhealth.vermont.gov/sites/dmh/files/resources/DMH-Public_Health_Approach_Summary.pdf

Governor's Early Childhood Advisory Council (ECAC) Leads: DCF and DPI (DHC, DOC, OCMH)	• Ensure that all children and families in Wisconsin have access to quality early childhood programs and services Ongoing
Leading Together Lead: DHS (DCF, DPI, OCMH)	• Support family leadership within state and county level policy, program, and quality improvement activities initiatives Ongoing
Mobilizing Action for Resilient Communities Lead: OCMH (WEDC)	• Educate three Wisconsin workplaces on the impact of adverse childhood experiences followed up with opportunity to learn and practice mindfulness 2015-2017
Project AWARE *(Advancing Wellness and Resilience Education)* Lead: DPI	• Enhance school safety and climate, and the coordination and integration of mental and behavioral health services • Train thousands of people in Youth Mental Health First Aid Three school districts: Adams-Friendship, Ashland, and Milwaukee 2014-2019
Safe Schools Healthy Students Lead: DPI (DCF, DHS, DOC, OCMH)	• Promote early childhood social and emotional learning and development • Promote mental, emotional, and behavioral health • Link families, schools and communities • Preventing behavioral health problems including substance use • Create safe and violent-free schools Three communities: Beloit, Menominee Nation, Racine 2013-2017
Race to the Top Lead: DCF (DHS, DPI, OCMH)	• Reinforce YoungStar • Strengthen family engagement • Create early childhood longitudinal data system 2013-2016

School Climate Transformation Lead: DPI	• Support for Positive Behavioral Intervention System (PBIS) • Develop a school-based mental health framework and needs assessment • Enhance supports for social and emotional development Fifty school and community teams 2014-2019
School Safety Research Lead: DPI	• Study the impact of PBIS plus bullying prevention in middle schools 2015-2017
Child Psychiatry Consultation Program Lead: DHS	• Provide consultation and education to primary care clinicians on children's mental health needs • Grant awarded to the Medical College of Wisconsin and Children's Hospital of Wisconsin Milwaukee and the northern public health region Ongoing
Early Childhood Comprehensive Systems Grant Lead: DHS (DCF, Fostering Futures, OCMH, WI Alliance for Infant Mental Health)	• Train therapists in Child Parent Psychotherapy • Train parents, caregivers and case workers in effects of trauma on children • Introduce Trauma-Informed Care to the community Three counties: Kenosha, Rock and Waupaca 2014-2016
Fostering Futures Lead: First Lady Walker (CANPB, DCF, DHS, DOC, DPI, OCMH)	• Incorporate trauma-informed practices into child and family-serving systems and organizations • Provide child welfare organizations with trauma-informed care training, consultation and technical support through collaboration with the WI Trauma Project initiative. Ongoing

In School Pregnant/Parenting Interventions, Resources and Education (InSPIRE) Lead: DPI (DCF, DHS, UW Extension/Technical College)	• Support school-age parents in completing their high school education and achieving higher education • Teach positive parenting and child development Twelve school districts and one Cooperative Educational Service Agencies Statewide (CESA): Adams-Friendship, Bayfield, Beloit, CESA 3, Fond du Lac, Green Bay, Janesville, Madison, Menominee, Milwaukee, Racine, Walworth Consortium (several school districts), West Allis-West Milwaukee 2015-2017
Care4Kids Leads: DHS and DCF	• Provide comprehensive and coordinated care to foster care children in ways that reflect their unique needs and trauma experiences Six counties: Kenosha, Racine, Waukesha, Ozaukee, Washington, and Milwaukee Ongoing
Children's Behavioral Health Initiative Lead: DHS (DCF and OCMH)	• Develop a more in-depth analysis of child/youth psychotropic prescribing practices • Increase education and awareness of evidence-based non-pharmaceutical interventions Ongoing
Collective Impact Lead: OCMH (CANPB, DCF, DHS, DOC, DPI)	• Increase access to effective services • Promote Trauma-Informed Care in child serving agencies • Increase child, family and community resiliency Ongoing
Mental Health Training-State and Local Juvenile Justice Systems Lead: DOC (DCF, DHS, OCMH)	• Train 40 juvenile justice workers and mental health professionals who will train others 2015-2016

"Now is the Time" Healthy Transitions Grant Lead: DHS (DCF)	• Increase awareness about early intervention signs and symptoms for serious mental health concerns and identify action strategies to use when a serious mental health concern is detected • Develop effective services and supports for youth, young adults, and their families as they transition to adulthood Two pilot counties: Outagamie and Jefferson 2014 - 2019
Permanent connections, Academics, Training and employment, Housing, and Social and emotional well-being (PATHS) Lead: DCF (DHS, DOC, DPI, DWD, DOA, OCMH)	• Reduce homelessness among vulnerable youth. Pilot sites: Dane and Rock counties and a four-county consortium (Door, Kewaunee, Manitowoc and Sheboygan) 2013-2016
Policy Academy on Justice Involved Youth with Behavioral Health Disorders Lead: DHS (DCF, DOC, DPI, OCMH)	• Create a school-based diversion from juvenile justice on the local level • Address policies on the statewide level • Participate in action planning to change policy on the national level 2015-2016
Promise Grant Lead: DWD (DPI, DHS, DCF)	• Improve services for youth SSI (Social Security Supplemental Security Income) recipients and their families leading to better outcomes, including graduating from high school ready for college and a career, completing postsecondary education and job training, and obtaining competitive employment in an integrated setting 2013 – 2018
Systems of Care Transformation Lead: DHS (DCF, DPI, DOC, OCMH)	• Expand the comprehensive, individualized system of care for children with complex behavioral health needs Ongoing

Youth Emergency Detention/Crisis Response Lead: OCMH (DCF, DHS)	• Examine root causes of Wisconsin's high rates of Emergency Detention and hospitalizations • Provide recommendations to improve crisis response and reduce hospitalizations 2015-2016

Projects of interest that are not based on state agency collaboration

DCF Trauma Project DCF	• Train mental health clinicians in Trauma Focused-Cognitive Behavioral Therapy • Educate parents, caregivers and case workers on trauma's impact on children • Provide TIC education to a partner in the community (e.g., primary health, schools, law enforcement, etc.) • Train mental health providers in Trauma Focused Child-Parent Psychotherapy and train four Wisconsin trainers to for Trauma Focused Child-Parent Psychotherapy Ongoing
Families and Schools Together DCF	• Implement evidence-based Kid FAST (Families and Schools Together) programs in neighborhoods identified as high need, based on DCF child welfare data for children 0-5 years in out-of-home care • Implement a pilot Baby FAST program to support young mothers e.g., helping them to have more effective, healthy relationships with the babies' extended families, often including biological fathers and grandparents. Funded through 2016
Juvenile Justice Network WI Council on Children and Families	• Provide best practice guidance for juvenile justice Ongoing
Post-Reunification Support Program DCF	• Reduce re-entry to foster care and improve outcomes for children and families by providing continued case management and support in the initial 12 months after reunification Ongoing

Tele-psychiatry Line DHS	• Provide services using Mendota Mental Health Institute psychiatry staff • Develop a technology training curriculum Ongoing
Trauma Sensitive Schools DPI	• Train an internal school TIC coach in 27 schools starting January 2016; train 25-30 internal school TIC coaches in the second cohort 2016 - 2019

FREQUENTLY ASKED QUESTIONS ABOUT CHILDREN/YOUTH PSYCHIATRIC EMERGENCY DETENTIONS

Wisconsin laws give law enforcement, with county approval, the authority to place children and adolescents in a hospital when there is a need to protect the young person from harming themselves or others; this is called an "emergency detention" and is commonly referred to as an "ED". In Wisconsin, these involuntary psychiatric hospitalizations are on the rise.[1] The Office of Children's Mental Health is examining data related to this alarming trend. In the meantime, we hope to answer some commonly asked questions related to involuntarily hospitalizing a young person.

FAQ #1: Can't the hospital fix the child?

Parents and/or professionals who request an ED may believe that the hospital will be an effective way to address a child's mental health or behavioral issues. In reality, many of these children are released back home within just a few days.[2] Even when the child has a treatable condition, the hospital is best equipped to offer short-term crisis stabilization, not long-term interventions. It is up to the parents, educators, social workers, and other community-based support people to examine what might be going on in a child's life that corresponds to the alarming behavior and subsequently to help the child and family develop a plan to address the child's needs in the community over the long-term.

FAQ #2: Don't we need to ED this child to get him/her access to mental health services?

Wisconsin faces a shortage of mental health providers. Many families spend months or even years on waiting lists trying to access services. As a result, some people believe that the only way to gain access to mental health professionals is to have the child hospitalized. While hospitalization does result in a mental health assessment, it does not guarantee access to ongoing services. In fact, an analysis of children on Medicaid in 2013 shows that only half of the young people received any mental health outpatient services following an ED. Even when children did receive follow-up therapy, most of the time they only received one or two sessions.[3] The exact reasons for this are unclear, but it is important for those working with a child to know that an ED is not a guarantee that services will be accessed. County human services can provide information about the types and extent of services available in the community.

FAQ #3: Isn't this a way to get him/her to take medications?

Hospital-based psychiatrists can prescribe medications. However, just because a youth is in a hospital under an ED does not mean that the detained young person can be forced to take medication; this

[1] Office of Children's Mental Health analysis of admission data from Winnebago Mental Health Institute (WMHI) shows that EDs have become a much larger proportion of youth admissions in the last decade.

[2] Based on WMHI admission/discharge data from 2003-2013, 2013 Medicaid records, and 2013 data from the Department of Health Services, Division of Mental Health and Substance Abuse Services (DHS/DMHSAS).

[3] Based on an analysis of 2013 Medicaid records and 2013 DHS/DMHSAS data.

requires an additional legal step which, according to data from the Department of Health Services' Winnebago Mental Health Institute, almost never happens for children and adolescents.

FAQ #4: Won't the hospital at least provide structure and routine in the midst of chaos?

Psychiatric hospitals provide structure and routine, which is something that might otherwise be missing from the life of a child in crisis. However, many hospital stays are too short for the youth to develop a new routine and subsequently sustain these benefits once out of the hospital. Even when stays are longer, the routine established is not generally one that can be easily replicated back in the community. For that reason, it makes more sense for those working with the child to try to build routine into the community setting. During high levels of family stress, structure and routine, though very helpful, are often hard to achieve. There may be other ways to temporarily remove a child from a stressful or chaotic home environment to allow for de-escalation, such as staying with other relatives or friends or using respite services where available.

FAQ # 5: When a young person starts talking about suicide or self-harm, don't we need to move him/her to a locked facility for 24/7 monitoring?

Suicide is a real risk, and everyone around a child is right to want to keep him safe. At the same time, many children and adolescents who express an intention to harm themselves feel overwhelmed and lack the language or communication skills to ask for help. When a child or adolescent expresses a desire to harm him or herself, it is important to take appropriate steps. These may include putting the child in contact with someone who knows how to question, persuade and refer (QPR); calling the HOPELINE; or arranging a thorough, face-to-face suicide assessment by a qualified mental health provider. Starting a conversation can help determine the best way to approach the situation to both keep the young person safe, and to reduce the short and long-term negative consequences related to having a child/family go through the ED process.

FAQ #6: Isn't it better than nothing?

When a child is in crisis, it's understandable to consider a hospital stay as a solution. However, there are clear downsides to submitting a child or adolescent to an ED. EDs can be a traumatic experience. Children and adolescents are often taken to the hospital in the back of a police car, often in handcuffs. They are taken to a facility often hours away from their home, family and friends, and made to stay with people they don't know. They may see other children who are in severe distress. If they are inappropriately placed, the treatment experience could be brief and positive outcomes may be minimal. Once they return home, children and adolescents may feel the stigma of being the subject of an emergency detention. The whole process is stressful for the child and family, time consuming for those involved, and very expensive. Unless there is a well-founded concern of serious impairment to the child based on a professional assessment, emergency detention and hospitalization may actually be detrimental to the child and family.

FAQ#7: What else can I do?

When a youth is in crisis and adults feel like they have few other options, it may seem that an ED is the only choice available. However, hospitals, psychiatrists, crisis workers, parents and schools report that many approaches do work. Here are some options:

- **De-escalate:** Oftentimes what appears to be an enduring crisis is a short-lived burst of intense emotion. By taking a few simple steps, adults can often assist the young person to successfully move through the emotions. These steps might involve bringing in people the child is close to (e.g., a grandparent, favorite teacher), silently being present, speaking calmly to the child and listening to the anger or fear without argument or judgment, modeling breathing techniques, taking the child for a walk to get out of an enclosed space, gently leaving the child alone to work through the emotions, etc.

- **Look for the least restrictive option:** EDs are the most restrictive and heavy-handed response to a crisis. If there is any way that a child can safely stay at his own home or at the home of a friend or family member (i.e., a diversion), this should be the first option. This may involve ongoing contact with crisis workers or other supports. If those options are not feasible, some areas have non-hospital crisis intervention or stabilization sites where youth can stay for a few hours or a few days. Voluntary hospitalizations are the next option, followed by EDs.

- **Plan ahead:** All adults working with a child or adolescent can help determine what situations trigger intense emotions and how such situations can be avoided or handled more successfully in the future. Many community resources are trained to do such planning. Comprehensive Community Services (CCS), Coordinated Services Teams (CST) Initiatives, Positive Behavioral Intervention and Supports (PBIS) Tier 3 folks, and Crisis Intervention workers are all trained to help develop an effective "planned response". These services can be accessed through your county and/or schools.

- **Use your primary care physician:** Primary care physicians can prescribe appropriate medications, or consult with psychiatrists to do so. Oftentimes what appears to be a medical or mental health issue is rooted in a traumatic or challenging situation in a child's life, so conversations about medication should ideally include questions about what else might be affecting the child.

- **Get support for the whole family**: Crisis workers frequently report that when they are called to deal with a child, what they find is that the whole family is experiencing distress. They see a pattern of youth going to the hospital only to return to the same home environment that sparked the crisis in the first place. Consider whether the parents might benefit from mental health or substance abuse treatment, peer support, parenting information, or even just time away. Parents who feel supported in their own lives have more resources to help stabilize their child.

CHILDREN'S EMERGENCY DETENTION AND CRISIS STABILIZATION CROSS AGENCY WORKGROUP SUMMARY

OVERVIEW: The cross agency work group was formed in response to an increase in the number of youth being sent to Winnebago Mental Health Institute (WMHI). County, state agency, provider, and parent representatives were concerned about this trend and set out to address it.

The initial workgroup was facilitated by the Department of Health Services-Division of Mental Health and Substance Abuse Services (DHS-DMHSAS) from September to October of 2014 ending with the short term goal of developing a residential crisis stabilization services for children that would reflect progress made in the adult system (e.g., crisis stabilization sites established as Community Based Residential Facilities and Adult Family Homes). This group also recommended promoting linkages between crisis services/crisis planning to Coordinated Services Teams and Comprehensive Community Services programming to ensure crisis plans for children and families are accessible among service systems. Longer term goals included the following: (1) Develop a youth crisis assessment and de-escalation training protocol for counties and crisis intervention partners, law enforcement, and school systems; (2) Expand coverage to include the home as a crisis stabilization site for hospital diversion funded by Medicaid; and (3) Investigate RCC's potential to be a resource for crisis services.

In January of 2015, the Office of Children's Mental Health agreed to facilitate the workgroup's continued meetings in order to better understand the problem and establish further recommendations. The information below is based on meeting activities and available information from both formal analyses (e.g., of hospital discharge data) and from stakeholder observations.

DESCRIPTION OF THE PROBLEM: Although the initial focus of the group was on the high census at WMHI, additional information was needed to put the WMHI numbers in context. For instance, an analysis of youth admissions from both state psychiatric facilities, WMHI and Mendota Mental Health Institute (MMHI), indicates that the number of youth admissions has not increased significantly, but the closure of MMHI youth beds shifted the entire youth population to WMHI. When this observation was made to stakeholders, they posited that the closure of MMHI youth beds did not fully capture the problem. Thus, more discussion and analysis resulted in an increased understanding about the trends at WMHI. Additional issues and information included the following:

- **Wisconsin has high rates of youth psychiatric hospitalizations** and these have increased in recent years even as other youth medical hospitalizations have declined.

- **Many of the hospitalizations are involuntary.** Though it is not possible to determine the exact number of Emergency Detentions, counties reported 1,066 youth (18 and under) were Emergency Detained in 2014. The actual number is likely higher due to inconsistent county reporting.

- **Psychiatric hospitalizations are expensive** and are the primary Medicaid expenditure for youth using mental health services.

- **Many hospitalizations can be avoided:** The data indicate that only a fraction of youth admissions at WMHI result in a civil commitment, settlement agreement, or post-probable cause confinement. The majority of youth legal issues are dropped before that point. Additionally, Medicaid data indicates that only half of youth who were known to have been Emergency Detained had any outpatient therapy in the calendar year of their detainment. It was also noted that youth with developmental disabilities are Emergency Detained for behaviors that, with the right training, could likely be addressed in less restrictive settings.

PROBLEM ANALYSIS: Although we may be unable to identify all the factors that contribute to Wisconsin's high rates of youth psychiatric hospitalizations and EDs, the workgroup collectively identified many facets of the problem as described below.

- **Strain on families***:* In Wisconsin, as well as the rest of the nation, we have seen an *erosion of the middle class* and an increase in the number of children living at or near the *poverty* line. Various health and human service sectors have noted this increased strain. The Department of Children and Families reports *increases in the number of children being removed from the home* and coming in *contact with the Child Protective System*. A variety of stakeholders report *increases in adult and youth substance abuse*. Anecdotally, educators report that children are expressing *more problem behaviors*.

- **Strain on mental health services:** Wisconsin has a pronounced *lack of mental health providers*. A report by Mental Health America placed Wisconsin 42nd in the nation in the number of providers, and a report by Kaiser Family Foundation ranked Wisconsin last in terms of the ability to meet mental health needs; this creates challenges in meeting children's needs for mental health screening, assessment, and outpatient treatment. Counties report that their *workforces are over-extended* and that their *staff lacks the support* they need to meet the service demand. Providers report that Wisconsin's *Medicaid (MA) has low reimbursement rates* for mental health services. In addition, *MA reimbursement is not available* for certain categories of preventative treatment (e.g. respite care for families in crisis). More positively, there is some indication that *youth detentions have decreased* in recent years which may, in part, be due to a growing recognition that mental health issues are at the core of many delinquent behaviors. Though a positive shift in youth treatment, this may place additional strain on the mental health system.

- **Strain on crisis services:** In a recent Department of Health Services' (DHS) county crisis services' survey (July 2015), the majority of counties pointed to *under-staffing and high employee turnover* as problems. This erodes the level of stability and expertise in crisis services; it also may lead to other practices that make Emergency Detentions more likely, such as:

  Reliance on law enforcement: In the crisis services' survey referenced above, many counties noted that they rely heavily on law enforcement to respond to crises and make determinations about the appropriate course of action, especially after hours. While law enforcement may have an important role to play in the crisis system, this over-reliance could inadvertently promote the use of primarily law enforcement related options.

  Lack of time to attend to the crisis: Best practice with youth in crisis dictates that enough time be allotted for a crisis worker to assess the situation, de-escalate, and work with the family to stabilize the youth. In the DHS survey, approximately half of the respondents (52%) said that they used face-to-face assessments most of the time. Some counties noted that they were more likely to use mobile crisis services when youth were involved. Some rural counties noted that while they are able to offer mobile services, in practice the travel time is a challenge with limited staff. Successful counties indicated that youth are most successful when the crisis response can be holistic and family-centered, and, when appropriate, lead to ongoing services.

  ***Lack of less restrictive options*:** The majority of counties surveyed expressed concern over the lack of youth hospital diversion or stabilization options. While most counties said that they try to divert individuals from hospitalization whenever possible, they noted that the lack of options makes this particularly difficult. Workgroup members and the counties reported that they are experiencing *increased strain on the foster care system* making it harder to use foster care licensed facilities for short-

term mental health stabilization. *The number of residential care centers has also declined* in recent years. Data from the Wisconsin Hospital Association Annual Surveys shows that the *number of psychiatric beds has declined*. In addition, counties report that many of the beds that have closed were youth beds and that *some hospitals have adopted new policies which* make it increasingly difficult to admit a youth on a voluntary basis. Instead, more *hospitals reportedly require an ED for admission*.

***Stakeholder knowledge and beliefs*:** Many counties expressed the need for more training for their staff in order to more effectively assess and de-escalate crises. In the DHS survey, many counties indicated that they were *only willing to see consumers in a secure environment* (e.g., hospital emergency room or police station), and/or that they require that police accompany crisis workers in non-secure environments. While it is imperative to protect crisis workers' safety, there may be ways to provide crisis services in less restrictive and potentially triggering conditions. Even when a crisis staff person determines / assesses that a situation can be safely handled outside of an Emergency Detention, counties report that sometimes other stakeholders take a *highly cautious approach and default to the side of an Emergency Detention* if there is any perception of risk. This has been mentioned with regard to law enforcement, corporate counsel, and hospital staff.

EXAMPLES OF COUNTY SOLUTIONS: Counties have been creative and proactive in seeking solutions. Below are some examples cited by the work group.

- Some counties are focusing resources *on early identification*, identifying youth at risk of crisis and targeting services to meet their needs.
- *Police CIT training* focused on serving youth.
- At least one county will *meet youth/family at the Emergency Room and follow-up with 15 to 20 hours of face to face services a week*. While another county provides an in-home treatment model that includes longer term treatment (more than 90 days).
- Several northern counties *stabilize youth in a non-hospital setting within 24 hours* but have very limited capacity. Others report using *foster and group homes*. While others are considering a 'flexible use' model to provide an *"hotel model" stabilization* – the parent stays with the child in a stable setting.
- Ten counties contract with a network to help serve and place youth. They offer *planned respite* for families out of general state revenue or county funds to be used as a diversion to hospitalization, as a step down coming out of hospital back into community, and as a planned response to address a need prior to crisis. This network also provides *training and technical assistance* for counties dealing with youth in crisis. They attribute much of their crisis diversion to *face-to-face assessment* which they also use to de-escalate the situation. If they feel a hospitalization is not necessary but services are needed, they can place the child in a ***stabilization site***, which could be a foster home, group home, or treatment foster home, all of which are licensed by DCF and must have specialized DHS 34 training.

NEXT STEPS: The group created three workgroups focused on improving crisis response. These include:

- **Best practices:** This group will collect and disseminate information on the best practices occurring nationally and within Wisconsin, both directly in the crisis system and in work with stakeholders (e.g., hospitals, law enforcement, schools). The information will serve as a standing resource for counties.
- **Training:** The Wisconsin County Human Services Association will lead an effort to help define a standard set of crisis training materials statewide.
- **New options for placement:** This group will design and pilot a regional group home that can be used in lieu of hospitalization for the purposes of crisis stabilization.

Appendix D-3: CEDCS Recommendations

CHILDREN'S EMERGENCY DETENTION AND CRISIS STABILIZATION WORKGROUP: RECOMMENDATIONS TABLE

Crisis Prevention	Crisis Intervention/Stabilization
Coordination	
Build and maintain relationships with schools and private insurers. Encourage MOUs with schools and health systems to identify and connect at-risk youth to services. County representatives noted that many crisis cases were unknown to them because they came from private providers/insurers.	**Coordinate internal efforts to free up staff resources.** Encourage county use of NIATx or similar quality improvement process to improve internal process (ex: Jefferson, Rock).
Promote and maintain linkages between tribal crisis and mental health services and county crisis and mental health services.	**Coordinate regional or statewide efforts to maximize use of resources.** Investigate what functions can be effectively regionalized or even handled at the state level. Ex: call centers, centralized psych bed coordination system.
Promote and maintain linkages between crisis services and Coordinated Service Teams and Comprehensive Services programming. Strong collaboration will ensure that crisis plans are available to every member of the youth/families' support team.	Meet with hospital associations/hospital administrators to address the perception that hospitals have adopted new policies which make it increasingly difficult to **admit a youth on a voluntary basis.**
Training	
Introduce information about the Adverse Childhood Experience Study and **trauma-informed care** to anyone who touches the life of a child. Provide **simple sensory de-escalation strategies** and information about **Wellness Recovery Action Plans (WRAP) plans** for providers, youth and families.	**Crisis Intervention Team (CIT) trainings for law enforcement.** This specialized training provides officers with information about mental health issues, reduces risks of injuries to consumers and officers, enhances working relationships with mental health providers, increases family involvement and reduces the need for more costly services.
Provide stakeholders with information about the **CST approach and CCS service array and approaches to suicide prevention**.	**Establish training protocol for crisis staff, school liason officers, school staff, corporation council and other stakeholders.** The training would focus on crisis assessments, de-escalation techniques, developing crisis plans, working with special populations (e.g., developmental disabilities, dementia patients), trauma informed care and cultural competency, working effectively with partners, identifying and addressing vicarious trauma and burnout.
Provide law makers, county supervisors, local leaders and businesses with information related to the **cost savings in investing in early intervention** versus youth crisis services and psychiatric hospitalizations.	**Train stakeholders (e.g., law enforcement, corporation council, schools, hospital staff) understand potential liability concerns so that EDs are not seen as a necessary default option.** In addition to concerns over legal liabilities, crisis workers express safety concerns over meeting youth in the home or community and limit contact to hospitals and police station. Training directed at reducing these concerns may increase successful crisis contact and planning.
Retain workforce by providing **training and support related to vicarious trauma through the development of Wellness Recovery Action Plans (WRAP) and reflective supervision**.	**Train service administrators on billing Medicaid for crisis intervention, stabilization, and related services.**
Access	
Incorporate specialized support into service array. Monitor the development of certification for Parent Peer Specialists and incorporate onto support teams. Occupational Therapists are often able to provide sensory strategies to be used for de-escalation.	**Establish out-of-home stabilization options (23-hours and/or motel model with parents on site) as well as in-home crisis stabilization services.** Explore potential for using Psychiatric Residential Treatment Facilities.
Review MA reimbursement rates and prior authorization practices for mental health screenings, assessments, and treatments with special attention to in-home, family-centered approaches.	**Partner with hospitals** to access voluntary youth psychiatric beds.
Plan respite using GPR or other funding source. Explore greater use of foster care options, group homes, family resource centers and Peer Run Respites, where available and applicable to age group.	**Provide mobile crisis services** to better meet youth and families 'where they are at'.

Appendix D-4: Crisis Response Continuum