Wisconsin Office of
Children's
Mental Health

2016 REPORT TO THE WISCONSIN LEGISLATURE

Wisconsin Office of Children's Mental Health (OCMH)
1 W. Wilson Street, Room 656
Madison, Wisconsin 53703
children.wi.gov

TABLE OF CONTENTS

EXECUTIVE SUMMARY **1**

INTRODUCTION **3**

WHAT WE DO **5**

A PUBLIC HEALTH APPROACH 5

CHILDREN'S MENTAL HEALTH THROUGH THE LENS OF SCIENCE 7

SYSTEMS CHANGE 11

HOW WE DO IT **13**

PARENT AND YOUTH PARTNERS 13

CHILDREN'S MENTAL HEALTH COLLECTIVE IMPACT EXECUTIVE COUNCIL 15

ACCESS WORKGROUP 17

TRAUMA-INFORMED CARE WORKGROUP 21

RESILIENCE WORKGROUP 23

ADDITIONAL OCMH ACTIVITIES 214

HOW WE MEASURE IT **26**

COLLECTIVE IMPACT 26

CHILD WELL-BEING INDICATORS 27

STAKEHOLDER RECOMMENDATIONS **38**

MANY THANKS **40**

2016 Wisconsin Office of Children's Mental Health Staff
Kim Eithun-Harshner, Operations Lead
Elizabeth Hudson, Director
Lynne Morgan, Research Analyst
Joann Stephens, Family Relations Coordinator

THE WISCONSIN OFFICE OF CHILDREN'S MENTAL HEALTH'S 2016 REPORT TO THE LEGISLATURE: EXECUTIVE SUMMARY

The Wisconsin Office of Children's Mental Health has a website! Those interested in learning more about the OCMH, as well the Wisconsin Children's Mental Health Collective Impact initiative, now have ready access. Many of the concepts and activities discussed in this report have their origins in the website's content – please pay us a visit.

In 2016, we continued our **mission** to *innovate, integrate and improve Wisconsin's child and family serving systems* with the resulting **vision** that *all Wisconsin children are safe, nurtured, and supported to achieve their optimal mental, social and emotional well-being*. This report outlines work done to realize both.

Innovative Frameworks: The OCMH continues to promote a *public health approach* to improve children's mental health; in this report, we highlight examples of work being done across multiple sectors in Wisconsin. A unique public health project, Mobilizing Action for Resilient Communities (MARC), got a kick-start with the creation of a mobile app designed for workplaces interested in learning about Adverse Childhood Experiences (ACEs) and mindfulness meditation as a strategy to develop workplace well-being. We have also created a set of talking points that align *beliefs about children's mental health with science.* Here, we identify beliefs and underlying assumptions and examine them in light of growing literature on the developmental nature of children's mental health. Finally, the report identifies our focus on *systems thinking* and the importance this plays in identifying multi-sectorial activities, unintended consequences, and habitual ways of going about our work.

Collaborative Work: Creating alternate frames to understanding the issues is not enough. The "HOW" section of our report describes many strategic actions that are underway, including the work of the Children's Mental Health Collective Impact (CMHCI). These efforts would largely be business-as-usual were it not for the Collective Impact Partners (parents and youth) who provide leadership in the CMHCI Executive Council and workgroups. The three CMHCI workgroups – Access to Services and Supports, Trauma-Informed Care, and Resilience – have identified gaps, strengths and needs and are ready to identify collective shared measures as they move to actions steps.

To ensure communication across state agencies, the OCMH hosts bi-monthly meetings where leadership gathers to highlight partnerships and to identify future collaborative opportunities. An overview of the many activities occurring across state agencies is outlined in a living document entitled, Wisconsin State Agencies Collaboration Grid. Another collaborative effort lies in the work of data integration, where state agencies are rising to the challenge of data sharing with the hope of using multiple data sets for descriptive, diagnostic, predictive, and prescriptive analytics.

Measuring Impact: The end of the report provides the culmination of a year-long collection of child well-being indicators that will, over time, provide high-level trends related to Wisconsin children's resilience, adversity, service status, and outcomes. The indicators tell a story of positive and negative influences impacting a child's life course as represented by a scale holding a balance of experiences represented by risk and resilience factors which may tip towards positive or negative outcomes.

The summary child well-being dashboard is a collection of all the indicators and provides the reader with a quick summary of the Wisconsin findings and our national standing. In general, the dashboard indicates Wisconsin's children experience better resilience factors than the national average (e.g. early prenatal care, four-year-old Kindergarten attendance, neighborhood safety, and positive adult mentors) and experience fewer than the national average of risk factors (e.g. poverty, stressors during pregnancy, single parent households, and substantiated child abuse or neglect). Wisconsin is ranked worse than the national average when it comes to several negative outcomes such as a high number of youth hospitalizations, juvenile arrests, and the youth suicide rate. Positive outcomes include young adults' employment, high school graduation rates, and positive mental health days.

Every adult in Wisconsin can have a role in creating relationships and environments where children are able to shore up the brain's architecture, reduce exposure to toxic stress, create supportive buffers to make stress more tolerable, offer treatments that work, and build overall relational wealth. The OCMH 2016 annual report to the legislature outlines the OCMH's dedication to this work.

Unless someone like you cares a whole awful lot, nothing is going to get better. It's not.

--Dr. Seuss

INTRODUCTION

National estimates indicate that as many as one in five children has a diagnosable mental health issue[1] and the Substance Abuse and Mental Health Service Administration (SAMHSA) estimates the US prevalence of childhood Serious Emotional Disturbance (SED) as one in eight children. In Wisconsin, approximately one in 10 children qualify as having a SED.[2] This translates into 66,896 to 80,275 Wisconsin children ages nine to seventeen having a mental health issue requiring treatment.

Data from the 2013 Wisconsin Youth Risk Behavior Survey (YRBS) indicates that approximately one in four high school students experienced symptoms of depression[3] while just over half report experiencing poor mental health at least one day in the last month. Additional findings from the YRBS include the following:

- 17 percent of youth purposely hurt themselves, without wanting to die, in the previous 12 months,
- 13 percent seriously considered attempting suicide during the previous 12 months,
- 12 percent made a plan about how to attempt suicide in the previous 12 months,
- 6 percent attempted suicide at least once in the previous 12 months, and
- 2.5 percent made a suicide attempt in the previous 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.

Finally, Wisconsin's youth suicide rate is almost 40 percent higher than the national rate.[4]

Contemplating the above information presents a stark picture of the challenges faced by many of Wisconsin's children[5] and families. Pairing this information with data related to the inavailability[6] and inadequacies[7] of the national and local mental health workforce confounds the problem.

---

[1] CDC and Prevention, "Mental Health Surveillance Among Children—United States, 2005-2011." May 17, 2013, 62(02): 1-35.

[2] SAMHSA URS Table 1: Number of Children with SED, age 9 to 17, by state, 2015.

[3] Students in this category answered affirmatively to the question of whether at any time in the past 12 months they had felt so sad or hopeless that they had stopped engaging in their usual activities.

[4] This and other information can be found on the Wisconsin Council on Children and Families data rich report on Wisconsin's children's mental health in May 2016 entitled, "*Meeting the Mental Health Needs of Wisconsin's Children*"

[5] The terms "child" and "youth" are used interchangeably except where otherwise specified. The term "family" is used in a broad sense to include parents, caregivers, relatives, close family friends, and nontraditional families.

[6] The Substance Abuse and Mental Health Services Administration projects that 12,624 child and adolescence psychologists will be needed to meet demand by 2020, but a supply of only 8,312 is expected.

[7] For example, the following researchers' state, "Current usual mental health care for children is generally ineffective." Garland, Ann F. et al. "Improving Community-Based Mental Health Care for Children: Translating Knowledge into Action." Administration and Policy in Mental Health, U.S. National Library of Medicine, January 2013. www.ncbi.nlm.nih.gov/pmc/articles/PMC3670677/.

Despite this daunting information, the OCMH intends to bolster hope. Throughout this report, the OCMH amplifies the chorus of parents, youth, advocates, and providers who understand improving children's mental health as the responsibility of every adult who touches the life of a child.

> *"It is our choices, Harry, that show what we truly are, far more than our abilities"*
>
> *--Harry Potter and the Chamber of Secrets*

The general population is beginning to understand children's mental health as less an absence of pathology but instead a state of social, emotional and mental well-being which includes the ability to develop friendships and connections with others; participate with confidence in school, the family, and the community; regulate emotions; and maintain high self-esteem with knowledge that one matters in the world.[8]

The Harvard Center on the Developing Child promotes a theory of change that requires adults master the "core capabilities" identified as self-regulation and executive functioning in order to pass these skills along to children. They present two complementary and mutually reinforcing ways to approach this work. "The first is to change the environments in which adults live, work, and access services—for example, by reducing the ways in which systems and services designed for adults living in poverty overload and deplete their self-regulation skills; minimizing stigma; and addressing basic needs to relieve some of the key stressors in people's lives. The second is to provide individuals with coaching or training in specific self-regulatory and executive function skills, such as strategies for assessing stressful situations and considering alternatives."[9]

The OCMH's broader focus does not diminish the importance of long-standing mental health improvement efforts such as increasing the availability and skills of mental health providers, improving crisis response, and establishing alternatives to youth psychiatric hospitalizations. We do, however, look to enhance these efforts using many of the strategies outlined in the following report.

Please note: This report is best read electronically to access hyperlinks and can be found at http://children.wi.gov/Documents/OCMH2016AnnualReport.pdf. A glossary of terms can be accessed here.

[8] Child Trends. "What Works. Definitions and Methodology." www.childtrends.org/what-works/definitions-and-methodology

[9] Cohen, Steven D. "Applying the Science of Child Development in Child Welfare System." (2016). www.ddcf.org/globalassets/child-well-being/16-1013-center-on-developing-child_childwelfaresystems.pdf

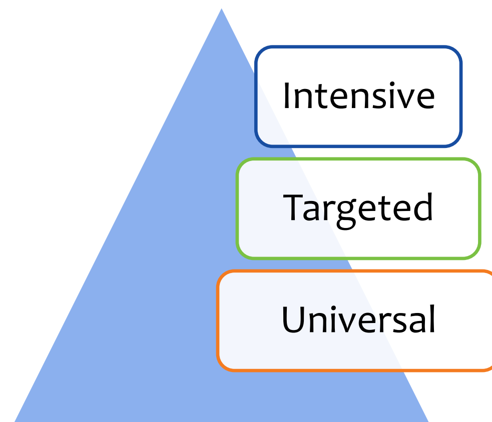
WHAT WE DO

A PUBLIC HEALTH APPROACH

The following directives from the Georgetown University Center for Child and Human Development[10] inform the OCMH's public health perspective which we highlight when participating on committees, providing consultations and presentations, collecting data, and meeting with stakeholders:

- Take a population focus, which requires an emphasis on the mental health of *all* children,
- Place greater emphasis on creating environments that promote and support optimal mental health and on developing skills that enhance resilience,
- Balance the focus on children's mental health problems with a focus on children's "positive" mental health, and
- Work collaboratively across a broad range of systems that impact children's well-being.

In line with these directives, we promote a multi-tiered (universal, targeted, and intensive) public health approach to improving children's mental health.



One long-standing example of a *universal* public health approach is the prenatal care provided to over 99 percent of pregnant Wisconsin women.[11] The OCMH envisions a time when all soon-to-be parents will not only receive this standard care, (e.g., education about diet and nutrition, exercise, immunizations, and the importance of abstaining from drugs and alcohol) but additionally will learn about the importance of relational wealth, emotional attunement, attachment, resilience, and the impact of Adverse Childhood Experiences (ACEs)[12] and toxic stress on the developing brain.

Equipped with this knowledge, caregivers will be more aware of the need to both build early resilience as well as the importance of preventing a host of negative experiences that may have life-long impact on physical, emotional, and mental health. Parental action would serve as a figurative early life vaccine for a child's later life challenges.

Another example of a tiered approach to the promotion of children's mental health includes behavioral health screening, a *universal* and *targeted* children's mental health approach occurring in

[10] Miles, Jon, et al. "A Public Health Approach to Children's Mental Health: A Conceptual Framework." *Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health* (2010).

[11] Pregnancy Risk Assessment Monitoring System, CDC. Data from 2011, analysis completed by OCMH.

[12] "Adverse Childhood Experiences in Wisconsin," www.preventionboard.wi.gov/Pages/OurWork/ACE.aspx

pockets of school districts across Wisconsin. With this practice, schools recognize the educational impact mental health issues have on children and seek to identify issues early to prevent events such as the following outlined in the Children's Defense Fund's Mental Health Fact Sheet:

- Children in elementary school with mental health problems are more likely to miss school than their peers – in one school year, children with mental health needs may miss as many as 18 to 22 days,
- Children in elementary school with mental health problems are three times more likely to be suspended or expelled than their peers,
- Almost 25 percent of adolescents who required mental health assistance reported having problems at school, and
- Almost 50 percent of adolescents in high school with mental health problems drop out of school. This is the highest dropout rate of any disability group.

Additional activities led by the Department of Public Instruction, and implemented across Wisconsin's school districts, include Positive Behavioral Intervention and Support (*universal, targeted, and intensive* approaches), Trauma-Sensitive Schools (*universal* approach) and school-based mental health (*targeted* and *intensive* approaches).

The Department of Health Services, Division of Care and Treatment Services will soon be increasing the availability of parent peer specialists by providing state sponsored training and certification, thus adding more mental health supports (*targeted* and *universal* approaches) to our workforce.

Many Wisconsin programs embrace universal, targeted, and intensive approaches to leverage the the power and strength of children's relationships with family, early childcare, pediatricians, schools, neighborhoods, and other social environments. Some of these programs include the following:

- Brighter Futures
- Community Response Program
- Connections Count
- Coordinated Services Teams Initiatives
- Early Childhood Systems
- Families and Schools Together
- Fostering Futures
- Four-year-old Kindergarten
- Home Visiting
- Safe Schools Healthy Students/Project AWARE
- School Climate Transformation/ Wisconsin School Mental Health
- School SBIRT (Screening, Brief Intervention, Referral to Treatment)
- Strengthening Families™ Protective Factors Framework
- Supporting Families Together Association
- Text 4 Babies
- Trauma-Sensitive Schools
- Triple P Parenting

- Waisman Center
- Wisconsin Alliance for Infant Mental Health Endorsement
- Wisconsin Early Childhood Collaborating Partners
- Wisconsin First Step
- Wisconsin Medical Home Initiative
- Wisconsin Model Early Learning Standards
- Wisconsin Pyramid Model
- YoungStar

Wisconsin's future depends on children being equipped with capacities that begin developing in early childhood when the brain's structures are most easily shaped; as such, these and other early child investments pay off in high future dividends.

CHILDREN'S MENTAL HEALTH THROUGH THE LENS OF SCIENCE

The topic of children's mental health received unprecedented Wisconsin media attention in 2016. The extensive coverage by USA TODAY NETWORK-Wisconsin provided readers with first-person narratives, data, trends in mental health, and the facilitation and coverage of in-person town hall meetings where people could share experiences and ideas to improve children's lives. Many of Wisconsin's parents, youth, and professionals have also led conversations and trainings that advanced our understanding of children's mental health.

Despite these efforts, there is still work to do to identify and address long-held, outdated beliefs about children's mental health that often interfere with the development and promotion of science-based policies and programs. The following table identifies several of the more common beliefs with the intention of furthering important discussions about children and children's mental health.

Children's Mental Health: Common Beliefs, Underlying Assumptions, and Science

<table>
<tr><th colspan="2">Belief: Children should be held accountable.</th></tr>
<tr><td>Assumption:
Children should know right from wrong and behave accordingly – if they don't, they should be punished.</td><td>Science:
Making children accountable for their actions should focus on strategies that create strong relationships, focus on social and emotional learning, and build executive brain function and self-regulation. ✧ Policies such as "zero tolerance" focus on mandatory punishment for certain behaviors which results in targeting children with impulse or emotion regulation control problems – issues that are not solved by punishment. ✧ To reduce the negative effects of arrests and disciplinary action, some communities work explicitly to bring down the number of arrests, suspensions, and expulsions by replacing them with responses such as restorative discipline/justice.</td></tr>
<tr><th colspan="2">Belief: Most adult treatments can be adapted to serve children.</th></tr>
<tr><td>Assumption:
Children's mental health needs are not inherently different than those of adults. Providers trained in adult interventions can meet the needs of children when no other resources are available.</td><td>Science:
Successful child therapy requires working effectively with, and providing consultation to parents and the other support people in a child's life, e.g., early learning, school employees, pediatricians. ✧ Childhood is a formative period and mental health issues are developmental in nature, thus children's mental health treatments, programs, and policies depend on greater understanding of the social, mental, and emotional development of children, as well as the interplay of genetic predispositions and environmental stressors.</td></tr>
<tr><th colspan="2">Belief: Families are soley responsible for their children.</th></tr>
<tr><td>Assumption:
Parents need to do a better job of raising their kids. If a child has a mental health issue, fix the parents, e.g., "the apple doesn't fall far from the tree."</td><td>Science:
Mental health issues are the result of genetics, biology, environment, and life experiences. ✧ Family members have an important role in support and recovery. Children are also influenced by schools, mentors, peer groups, and neighborhoods. Research indicates that when a child's environment is improved, mental health problems decline[13] and, conversely, when the most resilient children are placed in chronically stressful environments, the outcomes are often not good.[14]</td></tr>
</table>

[13] Costello, E. Jane, et al. "Relationships Between Poverty and Psychopathology: A Natural Experiment." *Jama* 290.15 (2003): 2023-2029. devepi.duhs.duke.edu/library/pdf/17227.pdf

[14] Vanderbilt-Adriance, E. L. L. A., and Daniel S. Shaw. "Neighborhood Risk and the Development of Resilience." *Annals of the New York Academy of Sciences* 1094.1 (2006): 359-362. www.ncbi.nlm.nih.gov/pubmed/17347377

Belief: Mental health issues are caused by a disease or illness located in the brain.	
Assumption: Mental illness is caused by a chemical imbalance which is largely the product of genes. Genes are immutable making prevention implausible. Medication becomes a logical response, even for very young children.	**Science:** Emotional and behavioral difficulties do not have biomarkers or laboratory tests to verify chemical imbalances. Research in the field of children's mental health has indentified numerous factors impacting mental health and well-being.[15] The field of epigenetics considers how relationships and the environment can influence neurobiology. We can impact a child's "destiny" by increasing resilience, decreasing exposure to toxic stress, and ensuring that services are available at the right time. ✧ There are many types of supports and therapies used to help children and young people and good physicians use great care when deciding whether and how to start a child on medication. Best practice is to couple medication with therapy and to closely monitor the child over time. ✧ Childhood is a formative period and mental health issues are developmental in nature. With this understanding, "prevention" is practical and necessary to ensure the well-being of future generations.
Belief: Making changes to how we address children's mental health necessitates additional funding.	
Assumption: We can't change our practices because of limited resources.	**Science:** There is no doubt that a financial commitment is needed to ensure that supports and services are available. There is also room to consider that long-held beliefs and assumptions may block or interfere with clear and creative thinking about children's mental health delivery and funding.[16]
Belief: We need to differentiate bad behaviors from mental health issues.	
Assumption: Punishment or behavioral modification is the best method to deal with behavioral problems. A mental health approach should be used with children	**Science:** Toxic stress can have negative effects on a child's brain development[17] leading to what appears to be "bad" behaviors. For example, a child who has been abused or neglected may misinterpret a teacher's neutral facial expression as anger, which may cause the child to become aggressive toward the teacher. In this instance, early abuse has led the young person to percieve safe

[15] O'Connell, Mary Ellen, Thomas Boat, and Kenneth E. Warner, eds. "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities." National Academies Press, 2009. National Research Council and Institute of Medicine. (2009). Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions.

[16] Bushe, G. and Marshak, P. "Revisioning Org Development: Diagnostic and Dialogic Premises and Patterns of Practice." *Journal of Applied Behavioral Science* 45: 348 (2009). http://jab.sagepub.com/content/45/3/348

[17] Child Welfare Information Gateway, Children's Bureau / ACYF "Understanding the Effects of Maltreatment on Brain Development". Washington, D.C., 2009. www.childwelfare.gov/pubPDFs/brain_development.pdf

who have diagnosible mental health issues such as depression, bipolar disorder, and anxiety.	situations as threatening and thus set off a flight or fight response. ✧ Traditional approaches to eliminate challenging behaviors include time-outs, detentions, suspensions, and spankings. These approaches are not recommended for young people with trauma histories as these strategies don't work to build executive functioning nor do they enhance relationships.[18] More appropriate recommendations include: CAPPD: Practical Interventions to Help Children Affected by Trauma, Time-Ins vs Time-Outs, No Drama Discipline, and Collaborative Problem Solving.
Belief: Children will grow out of it.	
Assumption: If we ignore the behavior and distress, it will go away.	**Science:** "Because children's brains are still developing, they are particularly receptive to the positive influences of youth development strategies, social and emotional learning, and behavioral modeling."[19] ✧ "Through greater understanding of when and how fast specific areas of children's brains develop, we are learning more about the early stages of a wide range of mental illnesses that appear later in life. Helping young children and their parents manage difficulties early in life may prevent the development of disorders. Once mental illness develops, it becomes a regular part of your child's behavior and more difficult to treat."[20]
Belief: Talking to parents and youth about trauma will be too uncomfortable and may cause problems.	
Assumption: People who learn about ACEs will be triggered and may need support and treatment services that are unavailable.	**Science:** Understanding the science can help to reduce shame and stigma as people come to view their history in terms of coping with and adapting to toxic stress, rather than as a story of personal failure. Learning more about the effects of adversity on development commonly produces a mix of validation (e.g., "this helps me understand what I encounter every day") and a new understanding of the sources of challenging behaviors.[21]
Belief: If we closely monitor young people with mental health issues, we can prevent most acts of	

[18] Greene, Ross "Lives in the Balance." www.livesinthebalance.org/

[19] Schwarz, S. National Center for Children in Poverty, Adolescent Mental Health in the U.S.: Facts for Policymakers, 2009. www.nccp.org/publications/pub_878.html

[20] National Institute of Mental Health: Treatment of Children with Mental Illness, 2009. www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml

[21] Cohen, Steven D. "Applying the Science of Child Development in Child Welfare System." (2016). www.ddcf.org/globalassets/child-well-being/16-1013-center-on-developing-child_childwelfaresystems.pdf

violence.	
Assumption: People identfied with mental health issues are more violent and dangerous.	**Science:** Studies suggest that violence by people with mental health issues, like aggression in the general population, stems from multiple overlapping factors interacting in complex ways. These factors include family history, substance use, stressors, poverty, and homelessness.[22] ✧ Less than 5 percent of violence in the U.S. is caused by people with mental health issues and a young person with these struggles is more likely to be a victim of violence – at four times the rate of the general public.[23]

Until we are able to examine and correct out-dated beliefs about children and families, many of our policies and practices will be undermined by well-meaning, but misinformed, stakeholders, leading to an unnecesarry cumulative toll on our young people, families, economy, and society.

SYSTEMS CHANGE

The OCMH's statutory directive to *improve, align, and support efficiencies across state agencies working to improve the lives of children and families* requires a shift from a traditional focus on programs to a more expansive perspective known as systems thinking.

In the context of our work, systems include service areas such as mental health, child protection, juvenile justice, education, early childhood services, etc. Systems thinking leads to questioning habitual ways of doing business such as examining how resources are allocated, identifying which values are prioritized within each system, examining why service siloes exist, and noting which relationships are nurtured or ignored. In other words, systems thinking is the difficult work of deconstructing and examining the invisible assumptions and habits that underly long-standing relationships and approaches. To assist in this process, the OCMH and the Children's Mental Health Collective Impact's Trauma-Informed Care Workgroup are using the "Habits of a System's Thinker" listed below:

- Seek to understand the big picture,
- Observe how elements within systems generate patterns and trends,
- Recognize that a system's structure generates its behavior,
- Identify the circular nature of complex cause and effect relationships,
- Make meaningful connections within and between systems,
- Change perspectives to increase understanding,
- Identify and examines the validity of underlying assumptions,
- Consider an issue fully and resists the urge to come up with a quick solution,

[22] Publications, Harvard Health. "Mental Illness and Violence" Harvard Health, www.health.harvard.edu/newsletter_article/mental-illness-and-violence

[23] U.S. Dept. of Health and Human Services, www.mentalhealth.gov/basics/myths-facts/

- Consider how mental models affect current reality and the future,
- Use understanding of system structure to identify possible leverage points for action,
- Consider short-term, long-term, and unintended consequences of actions,
- Recognize the impact of time delays when exploring cause and effect relationships, and
- Check results and changes actions if needed.

The Department of Health Services, Division of Care and Treatment Services (DCTS), Children Youth and Families Section uses systems thinking to enhance Wisconsin's "system of care" (SOC) through Coordinated Services Teams Initiatives (CST). SOC is not a program or treatment model but is instead a paradigm shift focused on a shared vision and core set of values. DCTS is promoting SOC transformation by embedding SOC values and principles in child-serving systems; developing infrastructures to support children and families throughout their interaction with service systems; and providing comprehensive, trauma-informed, culturally-sensitive, family-driven, evidence-based services.

Another example of a current systems change effort is the School District of Beloit's School-Based Diversion initiative, a project of the national Juvenile Justice Policy Academy. This multisystem project includes county representatives, parents, school staff, and staff from the Department of Children and Families, the Department of Health Services, the Department of Public Instruction, and the OCMH. The team works to reduce juvenile justice involvement by diverting youth with mental health and substance use disorders from arrest in schools and creating clear pathways to effective individualized assessments, treatments and supports. Within Wisconsin, this group will serve to inform local and state diversion policies and practices. Nationally, the group's work will inform the creation of a national tool kit.

HOW WE DO IT

Many groups across the country are using a collective impact framework to enact systems-level change. The collective impact framework aligns initiatives by bringing together a diverse group of stakeholders, providing extensive data related to identified problems, and working together to achieve common goals. The OCMH serves as the backbone to Wisconsin's Children's Mental Health Collective Impact (CMHCI) initiative which is described below.

PARENT AND YOUTH PARTNERS

The Collective Impact Parent and Youth Partners (CIPs) assumed greater leadership this year by ensuring collective impact activities are led by at least one CIP. The CMHCI initiative is now securely grounded in the stories and experiences of Wisconsin families and youth. They also developed an internal leadership structure consisting of two parents and one youth leader; together, they provide oversight (e.g., setting meeting agendas, taking minutes, and mentoring new partners) to the monthly CIP meetings. To date, the CIPs activities and impact has been wide ranging. Activities included the following:

> *"We can begin by doing small things at the local level, like planting community gardens or looking out for our neighbors. That is how change takes place in living systems, not from above but from within, from many local actions occurring simultaneously."*
>
> *-Grace Lee Boggs*

- Developed evaluation templates for the collective impact process,
- Developed an informational brochure about the CIPs, their role in collective impact, and how other parents and youth can apply,
- Established an internal communication network using Slack, an online tool,
- Held a trauma-informed care training for caregivers, parents, and youth,
- Hosted a viewing of the film "Paper Tigers" and examined its potential for bringing the topics of resilience and trauma-informed care to local communities,

- Participated in the Honest, Open, and Proud training to learn effective ways to share personal stories that will lead to systems change, and
- Participated on projects, committees, and workgroups such as:
    - Coordinated Services Teams (CST) Coordinating Committees in multiple counties
    - Children Come First Advisory Committee
    - Children Come First Conference
    - Chippewa County Children, Youth and Families Committee
    - Comprehensive Community Services (CCS) Coordinating Committees in multiple counties
    - Helping Hands, Healing Hooves, Ozaukee County therapeutic riding center
    - NAMI Fox Valley Family Support Group
    - Parent 2 Parent Mentors
    - Port Washington/Saukville School District's Character Counts Mental Health Committee
    - Shared Resource Group for the Wisconsin Medical Home Initiative
    - The Gathering, future respite care facility in Ozaukee County
    - Waukesha County's Trauma-Informed Care Partnership, Special Services Advisory Committee and Partnerships for Children's Mental Health Committee
    - Wisconsin Council on Mental Health
    - Wis. Admin. Code. ch. DHS 40 Advisory Committee
    - Wisconsin Trauma Project

Next Steps: CIPs will participate in a strategic planning process in January 2017 to ensure their continued effective leadership in collective impact activities.

CMHCI EXECUTIVE COUNCIL

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

Action Steps: The CMCHI Executive Council (CMCHI-EC) is responsible for providing overall guidance, vision and oversight to the collective impact process and three CMCHI workgroups. With the addition of parent and youth participation, the group has grown in its depth and breadth of knowledge related to system strengths and barriers.

"My experience with the Children's Mental Health Collective Impact initiative has been outstanding. The collective impact effort has deepened my understanding of the issues related to improving children's mental health access and outcomes, as well as accelerated United Ways' connections to state agencies' departments and programs."

Charlene Mouille, United Way of Wisconsin

Throughout 2016, this group discussed the following action domains:

- Strengthen children's physical, social, cultural, political, and economic environments in ways that promote optimal mental health and prevent mental health problems,[24]
- Provide a continuum of services and supports, from promoting mental health and preventing problems, to treating problems and reclaiming mental health,[25]
- Reduce stigma associated with mental health issues and improve access to services, and
- Integrate and align public services such as physical and mental health, education, social services, child welfare, and juvenile justice.

With the above domains in mind, the group identified ways to streamline efforts, share costs, share data systems, and leverage resources. The following list provides examples of how the group put these ideas into action in 2016:

Aligning and Increasing Access to Trainings: The group discussed the broad range of state agencies' trainings related to children and families with the intention of reducing duplication, sharing

[24] Bright Futures, "Addressing Mental Health Concerns," www.brightfutures.org/concerns/systems/conceptualizing.html
[25] Ibid

resources, and unifying training content to resonate across systems. One example, the DCF's Milwaukee Child Welfare Partnership, provides trainings to home visitors, child welfare workers, and foster and adoptive parents. Training topics such as child development, motivational interviewing, and reflective practice are applicable across child and family-serving systems. There are discussions now underway to add the Birth to 3 Program (housed in the DHS) to the list of partners providing and receiving these trainings, thus eliminating the need for duplicate trainings to be developed by the DHS. Another idea underway is the creation of a central state agencies' training calendar to make trainings accessible to a wide range of stakeholders and families.

Parent and Youth Voice: CIPs spoke of the value in attending trainings sponsored by Wisconsin's education and mental health systems and described how the information increased their ability to advocate for their children, connect to resources, and become empowered to help other families.

Sharing and Promoting Resources: The CMHCHI-EC learned about the 2-1-1 resource and the Wisconsin First Step Hotline. These tools link families to Wisconsin resources, community-based health and human services, and information. The presentation sparked discussions about how to better promote these tools, as well as ways state agencies and other stakeholders can financially support ongoing updates to the resource database.

Parent and Youth Voice: CIPs contributed additional resources and youth leaders provided suggestions related to the appearance, functionality, and messaging of the tool in order to better appeal to younger users.

Aligning Funding: Part of the CMHCI-EC work has been to examine strategies to best coordinate the funding streams supporting children's social and emotional development. For example, partners including the School Mental Health Framework (DPI), the Wisconsin Trauma Project (DCF), the Coordinated Services Teams Initiatives (DHS), the Comprehensive Community Services program (DHS), and the Child Welfare and the Courts team have coordinated county-level efforts to maximize training opportunities as well as pool financial resources. Pooled funding was sparked after the Children's Health Alliance of Wisconsin, the DCF, and the DHS experienced the benefits of family and youth participation (CIPs) in CMHCHI activities. This resulted in the contribution of financial resources to support the CIPs reimbursement for mileage and time.

Next Steps: The group will identify areas of improvement (see "HOW WE MEASURE IT") and will work together to secure funding to support the CIP's continued collective impact work.

ACCESS WORKGROUP

Goal Statement: Wisconsin's infants, 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.

Action Steps: In order to build on existing efforts, the Access Workgroup had presentations from successful Wisconsin programs, including the Child Psychiatry Consultation Program, the Early Childhood Mental Health Consultation, the Medical Home Initiative, the Post-Reunification Services, the Wisconsin School Mental Health Approach, the Wisconsin Trauma Project and Wisconsin Medicaid benefits for children's mental health services. Underlying action themes that are integrated into the Access Workgroup include:

- Become pro-active and less reactive,
- Build on what works,
- Prioritize the inclusion of parent and youth in policy and systems-level activities, and
- Promote a system of care approach to ensure a continuum of child and family supports and services in every county.

Parents and Youth Voice: The CIPs shared frustration in not knowing about or having had challenges accessing needed services. One parent expressed her regret in not having knowledge of the Birth to 3 program which she believes would have provided early support that may have reduced many of her family's current frustrations.

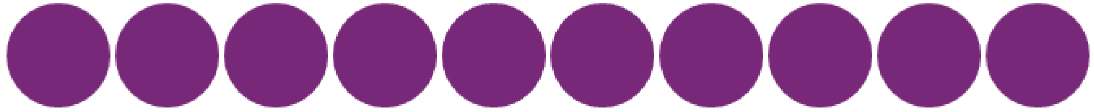
Next Steps: The Access Workgroup will develop an action plan based on the information collected in the following table.

The Access Workgroup has identified the following (1) key interventions; (2) intended outcomes should the interventions work, (3) existing resources to accomplish the aspirations, and (4) barriers to achieving the outcomes:

1) Key Interventions	2) Intended Outcome	3) Existing Resources	4) Barriers
Inform parents, youth, and providers of existing resources.	Connect families and providers. Increase access to services. Provide parents information about service array.	• 2-1-1 Database • Blueprint for Early Childhood Screening • Child Psychiatry Consultation Program • Wisconsin First Step	Physicians don't know where to refer children with mental health needs. Services are not equally available across the state. There is a lack of knowledge of the resources available for many families.
Expand trauma-informed practices and trauma-specific interventions across all agencies, using existing resources where possible.	Improve quality of care and access to appropriate services.	• Fostering Futures • Trauma-Informed Care CMHCI Workgroup • Wisconsin Trauma Project	Families are viewed through a deficit-based lens. There is stigma associated with trauma and mental illness.
Expand school mental health programs.	Improve quality of care and access to appropriate services.	• School Mental Health Approach	Children with mental health issues often struggle in school. Attending mental health appointments can exacerbate these problems due to missed class time. Parents have limited access to transportation, childcare and other resources, making accessing services outside of business hours difficult.
Expand use of parent peer specialists/navigators and other parent supports across systems.	Decrease the use of crisis interventions by providing proactive services to families. Reduce barriers to services, increase family and youth feedback and service satisfaction.	• Leading Together • Parent Peer Specialists Certification Workgroup • Wisconsin Family Ties	Lack of providers' understanding regarding family and youth experiences in navigating complex service systems.

1) Key Interventions	2) Intended Outcome	3) Existing Resources	4) Barriers
Improve the quality and options available for children's hospital diversion services and families experiencing heightened stress and crisis.	Decrease hospitalizations.	• Children with Complex Needs workgroup • Emergency Detention Crisis Stabilization Workgroup • Crisis Training and Best Practice Workgroup	There is not sufficient access to family and in-home therapy. Families may be unaware of alternatives and opt for youth hospitalization. Caregiver exhaustion often leads to youth hospitalizations.
Move to public-private partnerships and pay-for-performance to fund supports and services for children and families.	Move funding to prevention and early intervention in order to decrease need for hospitalizations.	None identified	Hospitalization insurance runs out before the youth is stabilized. Private insurance does not provide many of the services offered through the county such as wraparound and Comprehensive Community Services.
Create feedback loop for parents, youth and providers for ongoing quality improvement.	Enhance services with a continuous quality improvement process. Increase family voice. Increase quality of care.	• Coordinated Services Teams Initiatives survey • Family Experience Survey Workgroup collecting surveys from multiple state programs to align family metrics • Mental Health Statistics Improvement Program Survey • National Core Indicators: Children/Family Survey • WI Birth to 3 Program Family Outcomes Survey • WI State Performance Plan, Indicator #8 Parent Involvement	Existing services do not always meet the needs of the families and youth. The effectiveness of current programs is not often measured.

1) Key Interventions	2) Intended Outcome	3) Existing Resources	4) Barriers
Enhance providers' cross-system training. Provide coaching and learning collaboratives for organizations undergoing systems change efforts.	Blend funding or collaborate with organizations currently providing training. Increase effectiveness of providers.	• Behavioral Health Training Partnership • CESA Training Programs • Child Psychiatry Consultation Program • Child Welfare and the Courts – Children's Court Improvement Project • Crisis Intervention Training – Law Enforcement • Early Childhood Mental Health Consultation • Fostering Futures • Mental Health and Substance Abuse Education and Training • School Mental Health Approach (Training) • Supporting Families Together Association • Wisconsin Child Welfare Professional Development System • Wisconsin Trauma Project	Child and family-serving providers (school personnel, police, case managers, etc.) lack information about treating children with social, emotional, and/or behavioral challenges.
Provide family and youth-driven services.	Increase quality of care and receipt of appropriate services.	• Comprehensive Community Services • Coordinated Services Teams • Medical Home Initiative • Post-Reunification Services	Existing services do not always meet the needs of families and youth. Services and agencies are not asking families "What can we do to support you?"



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.

Action Steps: As referenced in the section of this report entitled, "WHAT WE DO," the TIC Workgroup has embedded systems thinking into the change process. The group has identified misguided beliefs guiding underlying many common practices across education, health services, and juvenile justice. Some of these false beliefs include:

- Children get what they deserve.
- One-time trainings change practice.
- Punishment teaches children a lesson.
- Staff always knows what is best for children and families.

"Only by changing how we think, can we change policies and practices…Only by changing how we interact can shared vision, shared understandings and new capacities for coordinated action be established."

-- Peter Senge, The Fifth Discipline

By identifying and correcting inaccurate assumptions, agencies have a better chance at achieving long-lasting improvement. In the absence of this examination, problems are more likely to resurface.

Parent and Youth Voice: A CIP described an experience when child and family visitation was denied due to the inconvenience it would cause staff. Following this interaction, the family could not shake the perception that staff viewed them as an inconvenience or problem versus a family with strengths and motivation.

Deeper examination helps identify leverage points where implementing small changes may have a large impact. For example, the TIC Workgroup's solution to the anecdote above would be to require that service providers ask, "What can I do to help?" prior to making recommendations or giving directives.

The Iceberg (Figure 1) is one of the tools the TIC Workgroup has used to examine systems and services underlying assumptions.

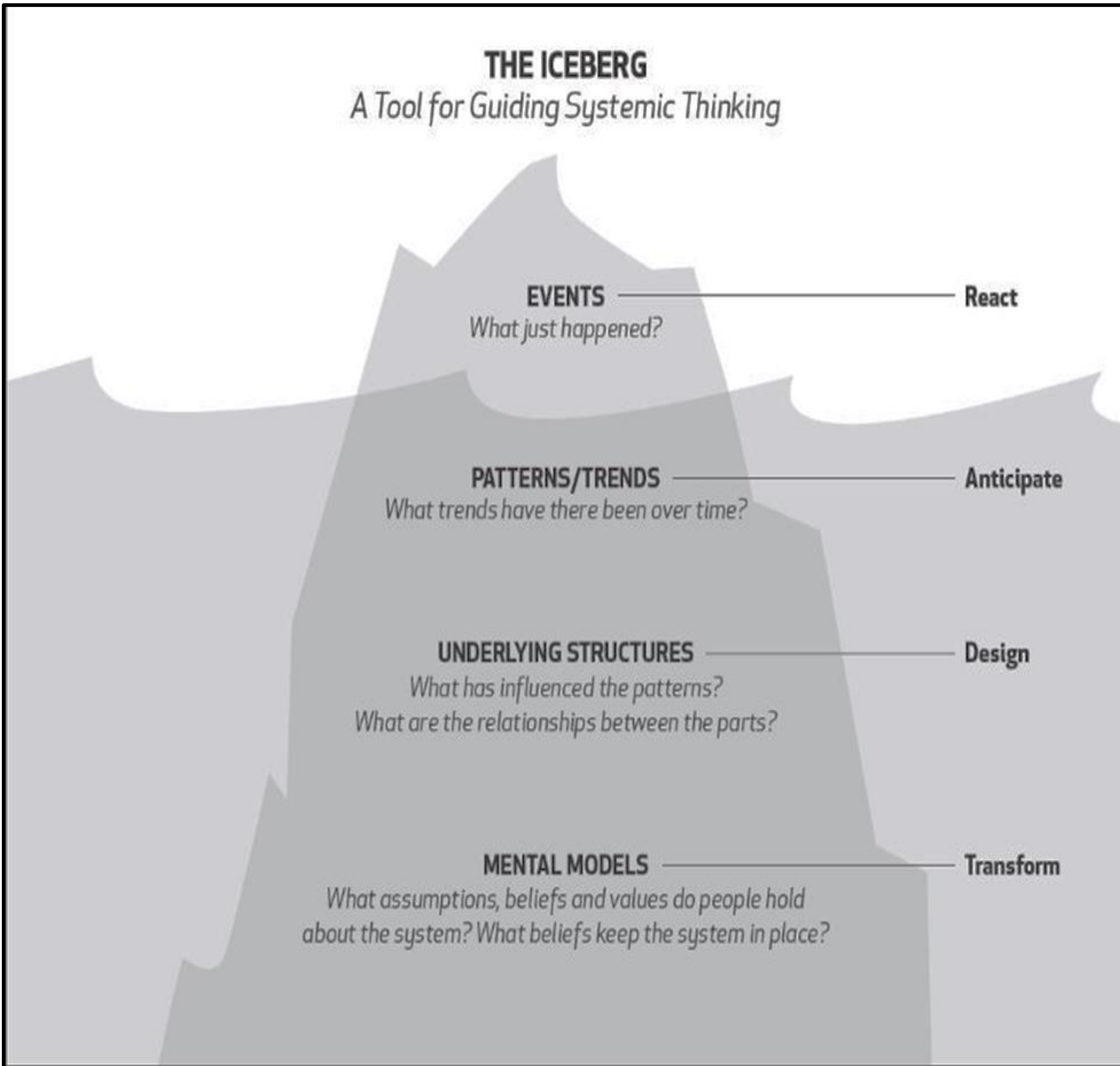
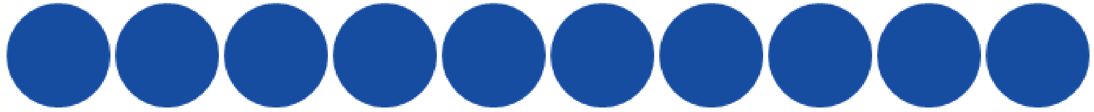


Figure 1. Iceberg Tool for Systems Thinking

Next Steps: The TIC Workgroup will monitor systems change by developing strategies to collect parent and youth experiences within service systems. The TIC Workgroup continues to encourage stakeholders to use the Wisconsin adaptation of the Missouri Model of Trauma-Informed Care to help guide organizations in TIC transformation.



RESILIENCE WORKGROUP

Goal Statement: All Wisconsin's infants, children, youth, and their families have accurate and timely information and the supports needed for social and emotional development, and optimal mental health and resilience, including relationships and social networks that provide friendship, love, and hope.

Action Steps: The Resilience Workgroup is committed to generating resilience within individuals, families, communities, institutions and systems by focusing on the following action steps:

- Define and promote a shared language and culture by creating a resource grid with a common definition of resilience and a collection of resilience tools to share with organizations,
- Build a "culture of resilience" across child and family-serving systems,
- Bring youth onto the Resilience Workgroup, and
- Track progress by monitoring the tools organizations use to build child, family, organization, community, and systems' resilience.

One highlight of the resource grid includes a Department of Public Instruction tool entitled Emotional Regulation Action Plans. This strength-based guide can be used by school staff to help children cope with stressful events and better regulate their behaviors. The Emotional Regulation Action Plans are available for students in grades PK to two, three to five, and middle/high school.

Parent and Youth Voice: Using the Emotional Regulation Action (ERA) Plan, a CIP parent was able to change the outcomes for a child who had been in four school placements over the course of nine months. By making the ERA Plan the center of the child's Individual Education Plan (IEP), the adults were in agreement about supporting the child's return to and stability in school.

Next Steps: The Resilience Workgroup is completing an action plan. In the meantime, the group continues to identify and incorporate tools into their practice and onto the resource grid.

ADDITIONAL OCMH ACTIVITIES

Fostering Futures: The OCMH staff provided trauma-informed consultation and trainings to county and state Fostering Futures teams. Under the leadership of First Lady Tonette Walker and the Fostering Future's Steering Committee, these teams seek to improve child and family well-being by integrating trauma-informed culture within agency/organizational policies and practices.

Kids in Crisis: Call to action for Wisconsin: A team of 25 USA TODAY NETWORK-Wisconsin journalists introduced readers to the issue of children's mental health in Wisconsin. In the spirit of community journalism, they also hosted town hall meetings across the state where attendees shared information and began to generate ideas for new approaches. The OCMH staff regularly discussed mental health issues with the journalists and provided consultation and panel participation during each of the town hall meetings.

Leading Together: Leading Together, part of the Wisconsin Medical Home Systems Integration Project, is a collaboration of family-led and family-supporting organizations. Together, these organizations share knowledge, identify areas where coordination can occur, and ensure that family voices are integrated into decision-making through strengthened family engagement and leadership.

Mobilizing Action for Resilient Communities (MARC): In 2016, MARC activities focused on introducing ACEs information and mindfulness strategies to Wisconsin workplaces. By bringing this information to the general population, the OCMH and our Wisconsin MARC partners intend to move Wisconsin towards a greater universal understanding of the impact of adversity and promise of resilience.

OCMH Logo and Website: The OCMH adopted a logo (found on the front page of this report) and created a website to increase visibility for the issues and activities surrounding children's mental health in Wisconsin.

Business Intelligence and Analytic Skill Development: Using the data analytic software, Tableau, the OCMH created a web-based, interactive format, displaying the counties children's mental health spending. We learned, however, that the publicly available spending reports used to produce the data were inaccurate and/or incomplete. In 2017, the OCMH is committed to working with counties and other stakeholders to develop additional visual data representations of services and spending.

State Agencies' Collaboration: The OCMH holds bi-monthly meetings with leadership from many state agencies, including the Department of Children and Families, the Department of Corrections, the Department of Health Services, and the Department of Public Instruction 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 that is housed on the OCMH website.

Trauma-Informed Care Policy Workshop: Over 40 people attended the OCMH sponsored TIC Policy Workshop. State agency representatives and other stakeholders used several tools to examine example policies using a trauma-informed approach. The OCMH will continue to offer opportunities to apply TIC to policy development in 2017.

Trauma-Informed Care Training for Parent and Young Adult Leaders: As TIC principles are adopted across multiple systems, the OCMH is committed to engaging families and youth in a parallel learning process. To this end, we provided a free training to an audience of 40 people highlighting information about the prevalence and impact of trauma and the availability of strategies and resources that lead to hope and healing. This training was recorded and is available on the hyperlink above.

HOW WE MEASURE IT

COLLECTIVE IMPACT

Evaluability Assessment of Wisconsin Collective Impact Coalition: As part of the MARC grant, the OCMH is working with external evaluators from Westat, a non-profit evaluation organization, to review the CMCHI process. In 2016, Westat completed interviews with 35 collective impact partners and collected 40 surveys regarding network connections.

As Westat discovered, it is difficult to measure collective impact. Typically, a standard evaluation process measures concrete activity such as number of trainings offered or number of people served by a particular program. Instead, collective impact evaluations measure less quantifiable outcomes such as enhancement of relationships, alignment of goals, and shared activities. As such, one of the evaluation strategies that Westat used was that of network connectedness (see Figure 2). This figure represents the high and low density connections in the CMHCI, illustrated by the darker and lighter connecting black lines across multiple child and family-serving sectors. The diagram visually indicates clusters where multiple partnerships might be impacted by a proposed aligned activity. This type of visual analysis highlights which sectors (and in other diagrams, which individuals) hold the most relational wealth with regard to child-serving systems change.

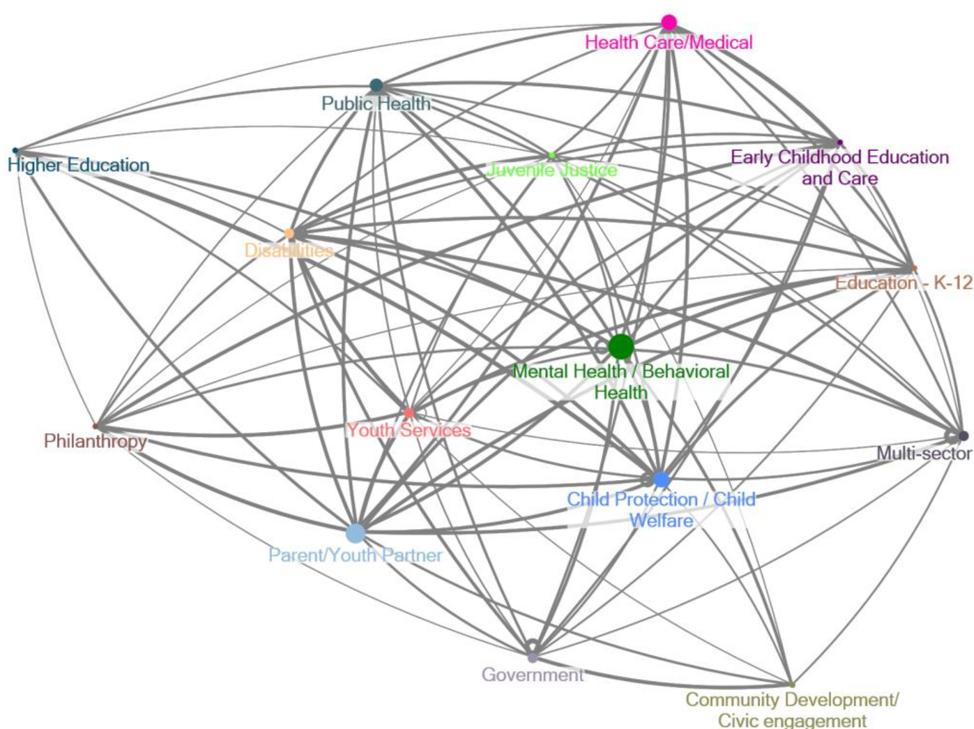


Figure 2. Children's Mental Health Collective Impact Network Analysis, 2016

Overall, Westat reported that the collective impact members and their organizations are beginning to align work with the overall goals and agenda of the CMHCI initiative and are also infusing the collective impact approach into their agencies activities.

The Westat evaluation highlighted "continuous communication" as an area of needed improvement. OCMH will address this in 2017 through the following activities:

- Listing monthly workgroup updates on the OCMH website,
- Distributing monthly emails written by collective impact participants, and
- Facilitating bi-monthly CMHCI-EC participants' presentations describing how the collective impact process has enhanced their work.

> *"It's good to have an end to journey toward, but it's the journey that matters in the end."*
>
> *– Ursula K. LeGuin*

CHILD WELL-BEING DASHBOARD AND INDICATORS

Resilience, Risks, Interventions, and Outcomes: How Wisconsin Stacks Up: The OCMH is tasked with tracking the effectiveness of Wisconsin state agencies support and services to children and families – this will occur when program outcome data is consistently available. In the meantime, the OCMH has identified a set of 48 indicators to track children's well-being from year-to-year.

One goal in highlighting the 48 indicators is to tell the story of positive and negative influences impacting a child's life course. Taking the lead from Frameworks Institute,[26] the OCMH uses the image of a scale to represent how a child may be impacted by a balance of internal and external factors as well as the impact of positive and negative experiences (see Figure 3).

Figure 3. Risk and resilience factors stacking up on either side of a scale.

[26] Kendall-Taylor, Noathanieal. "The Resilience Scale: Using Metaphor to Communicate a Developmental Perspective on Resilience." www.frameworksinstitute.org/assets/files/ECD/resilience_em_report_final.pdf

With the scale, we have a visual representation predicting that more protective, positive experiences tip the child toward resilience and overall positive outcomes. In contrast, more negative experiences without the balance of resilience factors will tip toward negative outcomes. The placement of the scale's fulcrum represents the child's internal factors, such as genetics and disposition. These factors impact how easy or difficult it is to move the fulcrum one way or the other. Ultimately, these indicators illustrate a theory of change – the more support children receive, the more hopeful their future.

> *"Promise me you'll remember, you are braver than you believe, stronger than you seem, smarter than you think"*
>
> *-- Winnie the Pooh, AA Milne*

CHILD WELL-BEING DASHBOARD

The 2016 OCMH Child Well-being Dashboard displays the 48 indicators, the values for Wisconsin and the U.S., and how Wisconsin is doing compared to the national average. The final columns show the highest ranking state and that state's value. Every year, the OCMH will update this data to track progress. Please note the following:

- arrows indicate a statically significant difference,
- arrow direction (up or down) indicates Wisconsin's status (better or worse) compared to the national average,
- numbers in parenthesis directly following each indicator represent the year(s) represented by the data, and
- full descriptions of each indicator and the lowest ranking states can be found here.

Wisconsin Office of
Children's
Mental Health

Resilience, Risk, and Outcomes: How Wisconsin Stacks Up

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

	Indicator (Year)	National	Wisconsin	Compared to National	Highest Ranking State
RESILIENCE INDICATORS	Early Childhood Screening ('11/'12)	30.8%	33.7%	↗	NC: 58%
	Early Intervention Services for Infants and Toddlers ('13)	2.8%	2.8%		MA: 8.89%
	Early Prenatal Care ('14)	70.8%	79.3%	↗	VT: 87.7%
	Eighth Grade Math Proficiency ('15)	33%	41.0%	↗	MA: 51%
	Four-Year-Old Kindergarten Attendance ('13/'14)	29%	70.6%	↗	FL: 79.5%
	Neighborhood Safety (Parental Perception) ('11/'12)	86.6%	89.5%	↗	ID: 94.7%
	Parents with Higher Education Degrees ('14)	37.7%	44.3%	↗	MN: 53.1%
	Positive Adult Mentor ('11/'12)	89.4%	94.2%	↗	SD: 98.1%
	Spending on Health/Wellness Promotion ('14/'15)	Not Available	$237/resident		N/A
RISK INDICATORS	ACE: Death of Parent ('11/'12)	3.1%	2.6%		CT: 1.4%
	ACE: Divorce ('11/'12)	20.1%	19.8%		DC: 15.2%
	ACE: Experienced Neighborhood Violence ('11/'12)	8.6%	7.5%		NJ: 5.2%
	ACE: Experienced Racism ('11/'12)	4.1%	2.5%	↗	VT: 1.8%
	ACE: Jailed Parent/Guardian ('11/'12)	6.9%	6.6%		NJ: 3.2%
	ACE: Lived with Someone who had a Problem with Alcohol or Drug ('11/'12)	10.7%	10.1%		NY: 6.4%
	ACE: Parent/Relative with Mental Illness Parent/Relative ('11/'12)	8.6%	9.7%		CA: 5.4%
	ACE: Socioeconomic Hardship ('11/'12)	25.7%	25.4%		MD: 20.1%
	ACE: Witnessed Domestic Violence ('11/'12)	7.3%	6.8%		CT: 5%
	ACE: Two or More ('11/'12)	22.6%	22.5%		NJ: 16.3%
	Experienced Cyber Bullying ('13)	14.8%	17.6%	↘	MS: 11.9%
	Poverty (Youth) ('15)	42.8%	36.9%	↗	NH: 24.8%
	Single Parent Households ('14)	35%	32%	↗	UT: 19.5%
	Stressors During Pregnancy ('11)	25.0%	22.5%	↗	GA: 17.7%
	Substantiated Child Abuse or Neglect ('14)	9.4/1,000	3.6/1,000	↗	PA: 1.2 per 1,000
INTERVENTION	Availability of Child, Family, School Social Workers ('15)	93/100,000	60/100,000	↘	MA: 312 per 100,000
	Availability of Psychiatrists ('15)	7.6/100,000	5.7/100,000	↘	DC: 36.5 per 100,000
	Availability of Psychologists ('15)	33.5/100,000	34.5/100,000	↗	MA: 73.4 per 100,000
	Insurance Coverage (Youth) ('15)	94.7%	94.3%		CT: 99%
	Mental Health Hospitalizations ('13)	199/100,000	223/100,000	↘	N/A
	Receive Treatment for Depression ('12 to '14)	35.9%	31.1%		NH: 57.9%
	Spending on Mental Health or Substance Abuse Treatment ('14/'15)	Not Available	$704/resident		N/A
NEGATIVE OUTCOMES	Alcohol Use (Youth) ('13)	34.9%	32.7%		UT: 11%
	Foster Care Placements ('14)	33.89/10,000	36.03/10,000	↘	VA: 20 per 10,000
	General Poor Mental Health (Youth) ('13)	29.9%	24.6%	↗	NE: 19.5%
	Homelessness (Youth) ('13/'14)	20/1,000	16/1,000		CT: 4 per 1,000
	Illegal Drug Use (Youth) ('13/'14)	9.2%	9.3%		IA: 6.31%
	Juvenile Arrests ('14)	39/1,000	109/1,000	↘	AL: . 6 per 1,000
	Mental Illness (Youth) ('13/'14)	19.8%	20.1%		MS: 16.29%
	School Suspensions & Expulsions ('11/'12)	6.6%	5.6%	↗	HI: 1.39%
	Suicide Rate (Youth) ('10 to '14)	5.33/100,000	7.28/100,000	↘	NJ: 3.01 per 100,000
	Teen Birth Rate ('14)	24.2/1,000	16.8/1,000	↗	MA: 9.7 per 1,000
POSITIVE OUTCOMES	Employment (Young Adults) ('14)	48%	58%	↗	IA: 67%
	Flourishing Behaviors (Children) ('11/'12)	73.2%	78.6%		WY: 85.2%
	Flourishing Behaviors (Youth) ('11/'12)	47.7%	49.7%		SD: 54.3%
	High School Graduation Rate ('13/'14)	82.3%	88.6%	↗	IA: 90.5%
	Home Ownership (Adults) ('14)	70.6%	71.1%		WV: 76.4%
	Positive Mental Health (Adults) ('14)	81.1%	83.0%	↗	HI: 89.3%
	Young Adults with Postsecondary Education ('15)	46.5%	45.7%		DC: 79.7%

Wisconsin Office of Children's Mental Health, 2016. Funding from The Health Federation of Philadelphia. For additional information and source documentation, visit children.wi.gov.
Up arrow indicates statistically significant improvement at $p<0.05$.

THE 48 CHILD WELL-BEING INDICATORS

Choosing Wisconsin Child Well-Being Indicators: The following criteria, as well as local and national resources,[27] were used to establish the child well-being indicators outlined in this report.

Indicator Criteria[28]	Indicator Description
Research-based	Strong evidence-base demonstrating its relevance to mental health and wellness.
Sensitive	Drawn from a data source that has large enough representative samples to reliably monitor changes over time.
Repeatable	Drawn from a data source that is regularly collected using a consistent data collection strategy.
Existing	Already collected through publicly-available data.
Available	Available for each state to allow national comparisons. Have elements that allow it to be disaggregated by race and county wherever possible.
Understandable	Can be easily understood by multiple stakeholder groups and key audiences, including parents and youth.
Comparable	Can be used to make comparisons by different demographic characteristics (e.g., by race, socioeconomic status) and/or geographic areas (e.g., by school district, city).

More information about each indicator is housed on the OCMH website. The following elements and descriptions are available for each indicator.

Element	Description
Life Course	**The category (Risk, Resilience, Interventions, Positive Outcomes, or Negative Outcomes) the indicator falls within.**
Brief Name	**The abbreviated name for the indicator.**
Indicator	**The full name of the indicator.**
Description	**A description of what the indicator measures.**

[27] Agencies included Wisconsin Department of Children and Families, Wisconsin Early Childhood Advisory Council, and Wisconsin Family Ties. Local and national resources included Community Indicators, Child Trends, Wisconsin's 2006-2007 Child Mental Health Plan, and information from states such as Oregon, Vermont, and Washington.

[28] Wilder Research, "The Hennepin County Youth Mental Health and Wellness Dashboard", February 2013 www.wilder.org/Wilder-Research/Publications/Studies/Hennepin%20County%20Youth%20Mental%20Health%20and%20Wellness%20Dashboard/Hennepin%20County%20Youth%20Mental%20Health%20and%20Wellness%20Dashboard,%20Full%20Report.pdf

Importance	**An explanation of why the indicator is important along with scientific research that supports the strength and appropriateness of the indicator.**
Limitations	**Drawbacks of using the measure or data source as well as what the data does not tell us and why we should interpret with caution.**
Source	**Where the data came from, along with references for the importance section.**
Numerator	**The number of people represented by the indicator category, e.g., "Who is included in this metric?"**
Denominator	**Number of people being considered, e.g., "Who is in the total population?"**
Values	
WI	**Wisconsin's value.**
US	**The national average.**
Best	**The top-ranked state and value.**
Worst	**The bottom-ranked state and value.**

Disaggregating Data by Race: The data represented on the dashboard are in aggregate, meaning the range in differences among various populations is incorporated into the whole. Due to time restraints, the OCMH was unable to provide an analysis of racially disaggregated data. Future reports will include these data and subsequent analysis.

Indicator Strengths: The indicators' data sources use sound methodology, large sampling frames, and repeatable data collection; these sources include the National Survey of Children's Health;

Current Population Survey (U.S. Census and Bureau of Labor Statistics); Youth Risk Behavior Survey (administered through the Wisconsin DPI and supported by the U.S. Centers for Disease Control), and the Behavioral Risk Factor Surveillance System, (administered by the Wisconsin DHS and supported by the U.S. Centers for Disease Control). The indicators highlight experiences and outcomes across the lifespan and are understood by most stakeholders as being relevant measures.

Indicator Limitations: Though these data sources are reliable, all data have limitations, many of which are detailed on indicator information sheets. In brief, please note the following information:

- *Hidden populations*: Without disaggregating the data (e.g., separating out the data to represent specific groups such as children living in poverty), subsets of the population cannot be discerned. These smaller populations are often the children and families for whom improved policies, aligned systems, and better programs will have the greatest impact.
- *Instability*: Most of the data are stable, meaning they do not randomly change year-to-year. However some indicators happen infrequently (e.g. youth suicide), so the differing rates may not be statistically significant.
- *Range of years*: Delays in the availability of national data sets are common; as a result, the indicators range from 2010 to 2016 thus the older 2010 data may not represent the current lives of young people.
- *Statewide versus local data*: Wisconsin is a large state with differences across regions, counties, and cities. Using the state average allows for comparison with other states, but does not provide a level of detail particularly helpful to county and local policy-makers.
- *Variability*: Some states vary in how they define a particular indicator. For example, in tracking substantiated child abuse and neglect reports, states follow the Child Abuse Prevention and Treatment Act (CAPTA) which is a federal law. Each state, however, may interpret the definitions of abuse and neglect differently.
- *Varied populations*: Most of the resilience and risk indicators capture the cohort of young people under the age of 18 as of 2012-2015. However, the cohort captured in the outcome measures is typically over the age of 18 as of 2012-2015. As a result, the childhood resilience and risk factors do not have a direct correlation to the interventions or the outcomes within the same year of data.

INDICATOR DESCRIPTIONS

Indicators Representing Resilience: According to the Harvard Center on the Developing Child (HCDC), "Positive experiences, supportive relationships, and adaptive skills build the foundation of what is commonly known as resilience."[29] Childhood resilience is the result of intrinsic factors (e.g., healthy birth, genes highly resistant to the impact of adversity) combined with the external environment (e.g., poverty and low-quality child care) in which children are raised.[30] The HCDC provides extensive resources on the science of resilience as well as interactive tools such as **"**Tipping the Scales: The Resilience Game.**"** The resilience indicators used by the OCMH include the following:

- Early Childhood Screening
- Eighth Grade Math Proficiency
- Early Intervention through the Birth to 3 Program
- Early Prenatal Care
- Feeling of Neighborhood Safety
- Parents with Higher Education Degrees
- Positive Adult Mentor
- Four-Year-Old Kindergarten Attendance
- Spending on Health/Wellness Promotion

"Resilience can be enhanced by building social capital at the neighborhood level, stress-buffering capacities at the caregiver level, and developing children's coping skills."

-Jack Shonkoff, JAMA Pediatrics

Indicators Representing Risks: Tolerable levels of stress during childhood are not only expected but desired. Children benefit from the manageable levels of stress related to exposure to new environments, learning new skills, and being challenged to problem-solve when faced with difficult situations. Children can also do well facing high levels of stress or adversity if they have supportive adult relationships. These situations often lead to the development of a well-functioning stress response system.

[29] Center on the Developing Child at Harvard University. "Applying the Science of Child Development in Child Welfare Systems", 2016, www.developingchild.harvard.edu

[30] National Scientific Council on the Developing Child, "Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13", 2015, www.developingchild.harvard.edu

In the absence of protective factors such as a caring adult, children who are exposed to child abuse or neglect, family turmoil, neighborhood violence, extreme poverty, racial discrimination, or other hardships can develop biological systems that are primed to become activated when faced with stress – this can lead to a child's frequent experience of "fight or flight" in situations that, in another child, would not provoke any response. With repeated exposure to a "high alert" response, the child may experience toxic levels of the hormones associated with stress – this is called "toxic stress." This toxic stress places a strain on the developing brain and body and is correlated to increased experiences of depression, drug and alcohol use, and anti-social behavior in early adulthood.[31]

> *"But the children knew, as I'm sure you know, that the worst surroundings in the world can be tolerated if the people in them are interesting and kind."*
>
> *--The Bad Beginning, Lemony Snicket*

Adverse Childhood Experiences (ACEs) are proxies for toxic stress, and in Wisconsin's child population, 24.6 percent children have one ACE, and 22.5 percent of children have two or more ACEs.[32] Nationally, youth in the juvenile justice system have ACE scores three to four times higher than in the rest of the population.[33] In Wisconsin, 98 percent of youth in Lincoln Hills and Copper Lake School for Girls' had one or more ACEs, and 64 percent had three or more.[34] The risk indicators listed on the OCMH dashboard include the following:

- ACEs
    - Death of a Parent
    - Divorce or Separated Parents
    - Experiencing or Witnessing Neighborhood Violence
    - Experiencing Racism
    - Having a Parent or Guardian Serve Time In Jail
    - Living with Someone with a Problem with Alcohol Or Drugs
    - Living with a Parent or Relative With A Mental Illness Diagnosis
    - Living with Socioeconomic Hardship
    - Witnessing Domestic Violence
- Experiencing Cyber Bullying
- Having a Mother Who Experienced Stressors During Pregnancy
- Poverty
- Single Parent Household
- Substantiated Child Abuse or Neglect

---

[31] Schilling, Elizabeth A., Robert H. Aseltine, and Susan Gore, "Adverse Childhood Experiences and Mental Health in Young Adults: A Longitudinal Survey." *BMC public health* 7.1 (2007): 1.

[32] Analysis done by OCMH using data from the National Survey of Children's Health, 2011-2012.

[33] Baglivio, Michael T., et al. "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders." *Journal of Juvenile Justice* 3.2 (2014): 1.

[34] WI Department of Corrections data are based on youth at Lincoln Hills and Copper Lake Schools from February 2013-January 2014.

Indicators Representing Interventions: The second section of indicators represents interventions for children with identified mental health issues. Many additional services are not represented due to the unavailability of state-wide data. The metrics listed here are consistently available and measured nationally. Intervention indicators include the following:

- Availability of Providers
    - Child, Family, or School Social Workers
    - Psychiatrists
    - Psychologists
- Insurance Coverage
- Mental Health Hospitalizations
- Receiving Treatment for Depression
- State Spending on Mental Health and Substance Abuse Treatment

Indicators Representing Negative Outcomes: The next section includes negative outcomes resulting from a complex mix of a child's genetics, adverse experiences, and protective factors. The negative outcomes indicators include the following:

- Alcohol Use
- General Poor Mental Health in Youth
- Homelessness
- Illegal Drug Use by Youth
- Juvenile Arrests
- Incidence of Mental Illness
- Placement in Foster Care or Out-of-Home Care
- School Suspensions and Expulsions
- Suicide Rate
- Teen Birth Rate

Indicators Representing Positive Outcomes: Surveys frequently focus on risks and negative outcomes which create challenges in tracking positive adolescent and young adult well-being metrics. The following are proxies representing a positive adult trajectory in the areas of education, employment, socio-economic status and behavioral health:

- Employment
- Flourishing Behaviors for Children (0-5) and Youth (6-17), such as displaying curiosity, calm when faced with challenges, and completes plans
- High School Graduation Rate
- Home Ownership
- Positive Mental Health
- Young Adults with Postsecondary Education

CHILD WELL-BEING DASBOARD AND INDICATORS SUMMARY

The dashboard indicates that Wisconsin children experience more than the average resilience-building experiences, while also experiencing fewer than the national average number of risk factors. This begs the question, "Why aren't outcomes better?" The following questions serve as a starting point for a larger discussion among stakeholders:

Resilience Indicators

- Do we lack resilience-building strategies for adolescents?

Risks

- Are we missing risk factors that may contribute to negative outcomes? For example, is technology reducing the necessary quality and quantity of real-time relationships? Is the reduction of time spent engaging in creative "free play" contributing to negative outcomes?
- Are we capturing the impact of Wisconsin's escalating drug and alcohol use?

Interventions

- Does the lack of available, effective interventions contribute to negative outcomes?

Outcomes

- Are we missing a group of indicators that would highlight abilities in the areas of executive functioning, emotional regulation, and depth of relationships – factors that often represent the capacity to achieve success in early and later life?
- Are we identifying the children with complex needs early enough?

Methodology

- Are we missing indicators that will lead us to better understand the reasons for our poorer outcomes?
- Are we looking at a time-lag in results? For example, did the young people who are represented in the outcomes section have lower resilience and higher risk indicator scores than the current group of children represented here? Fifteen years from now, will we see the impact of our higher levels of resilience and lower levels of adversity?

Analysis

- Does the small subset of youth who do not receive adequate protective factors, or who have high levels of adversity, subsequently develop such dramatic negative outcomes that our state shifts to lower than the national average?
- If we disaggregate populations with complex needs, will we see a stronger correlation between risk/resilience and the outcomes we expect?

STAKEHOLDER RECOMMENDATIONS

In January of 2016, USA TODAY NETWORK–Wisconsin wrote a Call to Action which began their deep-dive into coverage of Wisconsin's children's mental health. The recommendations in figure 5 below represent input the journalists received from a variety of sources including citizens who attended the town hall meetings. USA TODAY NETWORK-Wisconsin continues to report on progress towards achieving these recommendations in a section called, Kids in Crisis: Legislative Action Tracker.

(Please note the OCMH, and not USA TODAY NETWORK-Wisconsin, has used a public health pyramid to order the recommendations below. The bottom of the pyramid represents universal or prevention approaches, the middle identifies targeted approaches, and the top lists more intensive approaches.)

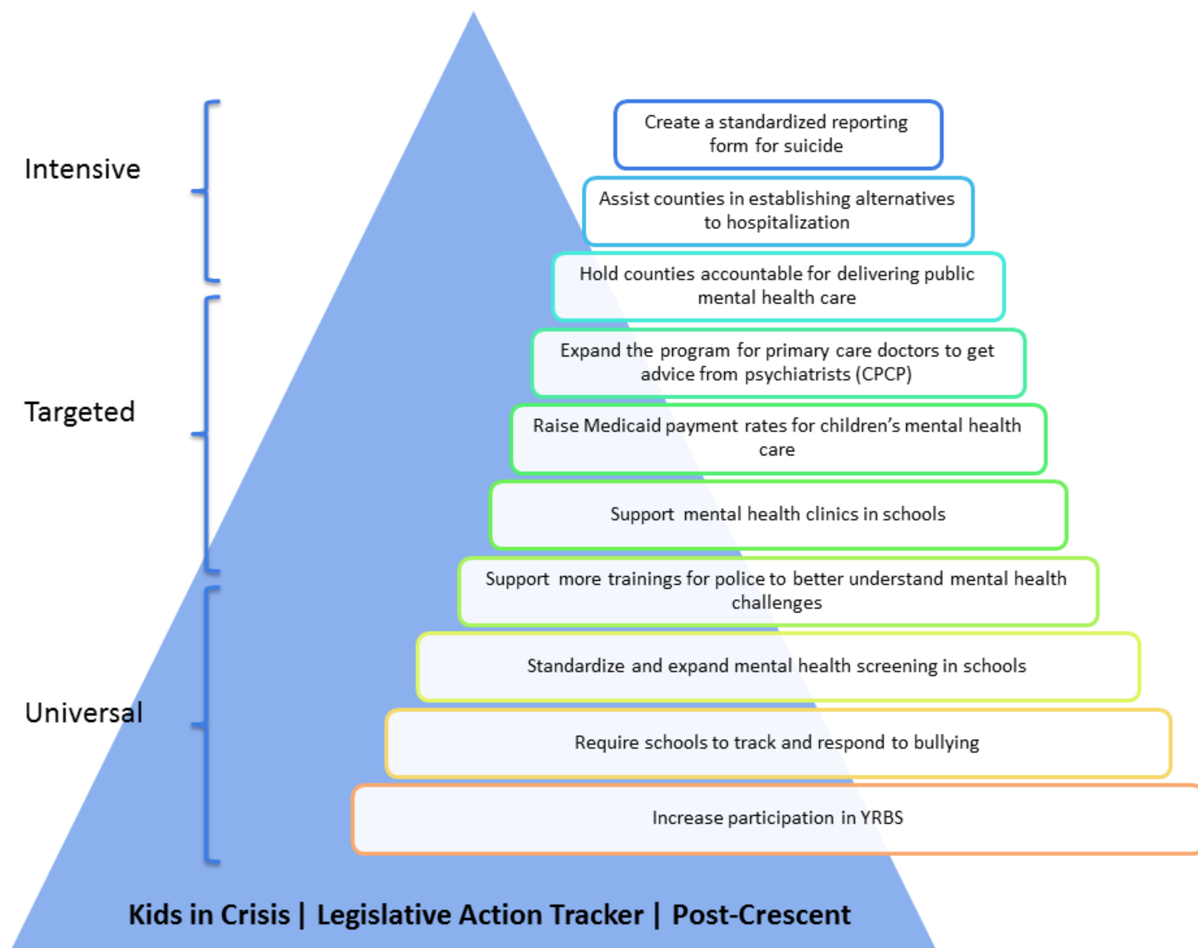


Figure 4. Kids in Crisis Legislative Action Tracker. Recommendations to improve children's mental health, 2016. From PostCrescent.com.

Other stakeholders such as the Wisconsin Council on Children and Families (WCCF), the Wisconsin Council on Mental Health's Children and Youth Subcommittee (C&Y), and the Governor's Early Childhood Advisory Council (ECAC), also documented recommendations which are represented in the table below:

Recommendations	USA Today	WCCF	C&Y	ECAC
Data				
Improve data and data integration/monitor children's mental health	X	X	X	X
Standardize suicide reporting	X			
Increase school participation in YRBS	X			
Improve data collection on student bullying	X			
Primary Care				
Expand Child Psychiatric Consultation Program	X	X	X	
Integration of mental health and primary care	X			
Prevention				
Increase home visiting				X
Increase 4 and 5 Star sites for YoungStar				X
Schools				
Screen for mental health issues in schools	X			X
Provide and evaluate school mental health services	X	X	X	
Service Array				
Standardize service arrays across all counties	X			
Prevent youth hospitalizations	X			
Expand the Pyramid Model			X	
Expand the Trauma Project's TF-CBT activities			X	
Expand trauma-informed system with at-risk preschoolers			X	
Fund communities to improve 0-3 support				X
Workforce Development				
Increase MA rates and streamline prior authorization	X	X	X	
Include family/youth voice with the provision of stipends for participation				X
Increase law enforcements' use of Crisis Intervention Team training	X			
Mandate coverage for tele-mental health by private insurers		X		

MANY THANKS

The following people have dedicated a great deal of time and attention to ensuring that the 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	
Tina Buhrow, co-chair	Collective Impact Partner
Kimberlee Coronado, co-chair	Collective Impact Partner
Arianna Keil, co-chair	Children's Health Alliance of Wisconsin
Karen Ordinans, co-chair	Children's Health Alliance of Wisconsin
Joyce Allen	Department of Health Services
Micheal Bostrom	Collective Impact Partner
Fredi Bove	Department of Children and Families
Rebecca Collins	Department of Public Instruction
Tabitha DeGroot	Collective Impact Partner
Kim Eithun	Office of Children's Mental Health
Terri Enters	Department of Health Services
Bob Fredericks	Collective Impact Partner
Phyllis Greenberger	Disability Rights Wisconsin
Linda Hall	Wisconsin Association of Families and Children's Agencies
Jennifer Hammel	Children's Hospital of Wisconsin
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-Glenn	Department of Health Services
Sheri Johnson	Medical College of Wisconsin
Rob Kaminski	Collective Impact Partner
Kia LaBracke	Wisconsin American Academy of Pediatrics
Leah Ludlum	Department of Health Services
Bonnie MacRitchie	Department of Children and Families
Linda McCart	Department of Health Services
Shelby McCulley	Department of Corrections
Lynne Morgan	Office of Children's Mental Health
Charlene Mouille	United Way of Wisconsin
Rebecca Murray	Child Abuse and Neglect Prevention Board
Gail Nahwahquaw	Department of Health Services
Lana Nenide	Wisconsin Alliance for Infant Mental Health
Tracy Oerter	Children's Hospital of Wisconsin
Chuck Price	Wisconsin County Human Services Association
Amanda Reeve	Department of Children and Families

Camille Rodriguez	Department of Health Services
Romilia Schlueter	Supporting Families Together Association
Kayla Sippl	Department of Health Services
Corbi Stephens	Collective Impact Partner
Joann Stephens	Office of Children's Mental Health
William Swift	WI American Academy of Child and Adolescent Psychiatry
Karissa Vogel	Mental Health America of Wisconsin
Mai Zong Vue	Department of Health Services
Cody Warner	End Domestic Abuse Wisconsin
Monica Wightman	Department of Public Instruction
Alison Wolf	Collective Impact Partner
Joe Zeimentz	Collective Impact Partner

CHILDREN'S MENTAL HEALTH COLLECTIVE IMPACT PARTNERS (PARENT AND YOUTH)		
Micheal Bostrom	Tabitha DeGroot	Corbi Stephens
Tina Buhrow	Bob Fredericks	Alison Wolf
Kimberlee Coronado	Robert Kaminski	Joe Zeimentz

CHILDREN'S MENTAL HEALTH COLLECTIVE IMPACT WORKGROUP MEMBERS

Access Workgroup

Joyce Allen, Co-Chair	Department of Health Services
Rob Kaminski, Co-Chair	Collective Impact Partner
Amber Arb	Department of Health Services
Kathryn Bush	Department of Public Instruction
Susan Cochran	Department of Health Services
Kimberlee Coronado	Collective Impact Partner
Kim Eithun	Office of Children's Mental Health
Jennifer Hastings	Kids Matter Inc.
Cheryl Jatczak-Glenn	Department of Health Services
Sarah Kate Johnson	Department of Health Services
Naomi Kowald	Children's Health Alliance of Wisconsin
Linda McCart	Department of Health Services
Lynne Morgan	Office of Children's Mental Health
Kathy Schoff	Family Service Madison, Inc.
Teresa Steinmetz	Department of Health Services
Joann Stephens	Office of Children's Mental Health

Trauma-Informed Care Workgroup

Tina Buhrow, Co-Chair	Collective Impact Partner
Kia LaBracke, Co-Chair	Wisconsin Chapter of the American Academy of Pediatrics
Donna Burns	Wisconsin Trauma Project
Michelle Buehl	Department of Corrections
Amy D'Adarrio	Children's Health Alliance of Wisconsin
Nic Dibble	Department of Public Instruction
Kim Eithun	Office of Children's Mental Health

Kasey Kaepernick	Waupaca County Human Services
Leslie McAllister	Department of Children and Families
Lynne Morgan	Office of Children's Mental Health
Joanette Robertson	Department of Health Services
Ann Rolling	Children's Hospital of Wisconsin
Dana Romary	Department of Health Services
Joann Stephens	Office of Children's Mental Health
Emily Tofte	Department of Children and Families
Kimberly Wild	Department of Children and Families
Lori Wittemann	Department of Health Services

Resilience Workgroup	
Cody Warner, Co-Chair	End Domestic Abuse Wisconsin
Corbi Stephens, Co-Chair	Collective Impact Partner
Paula Brown	Department of Children and Families
Kim Eithun	Office of Children's Mental Health
Carrie Finkbiner	Wisconsin Alliance for Infant Mental Health
Peggy Helm-Quest	Department of Health Services
Laurice Lincoln	Department of Health Services
Jenell Lorek	Children's Hospital of Wisconsin
Rebecca Mather	Child Abuse and Neglect Prevention Board
Lynne Morgan	Office of Children's Mental Health
Rebecca Murray	Child Abuse and Neglect Prevention Board
Romilia Schlueter	Supporting Families Together Association
Joann Stephens	Office of Children's Mental Health
Rebecca Wigg-Ninham	Department of Health Services
Monica Wightman	Department of Public Instruction
Alison Wolf	Collective Impact Partner

OCMH ADVISORY COUNCIL AND STATE AGENCY COLLABORATIVE COMMITTEE MEMBERS	
Joyce Allen	Department of Health Services
Fredi Bove	Department of Children and Families
Paula Buege	Collective Impact Parent Partner
Rebecca Collins	Department of Public Instruction
Patrick Cork	Department of Health Services
Casey Himebauch	Office of the Governor
Cheryl Jatczak-Glenn	Department of Health Services
Michelle Jensen	Child Abuse and Neglect Prevention Board
Shelby McCulley	Department of Corrections
Gail Nahwahquaw	Department of Health Services
Deb Rathermel	Department of Health Services
Amanda Reeve	Department of Children and Families
Camille Rodriguez	Department of Health Services
Teresa Steinmetz	Department of Health Services

OCMH RESEARCH ADVISORY COUNCIL	
Tim Connor	Department of Health Services
Andrea Gromoske	Department of Health Services
Ellie Hartman	Department of Workforce Development
Kelsey Hill	Department of Corrections
Daniel Kiernan	Department of Health Services
HeeJin Kim	Department of Children and Families
Kate McCoy	Department of Public Instruction
Matt Walsh	Department of Children and Families
Angela Witt	Department of Health Services
Joe Zeimentz	Collective Impact Parent Partner & Healthy Minds Innovations

OCMH 2016 ANNUAL REPORT REVIEWERS	
Joyce Allen	Department of Health Services
Fredi Bove	Department of Children and Families
Tina Buhrow	Collective Impact Parent Partner
Rebecca Collins	Department of Public Instruction
Jason Fischer	Department of Health Services
Shel Gross	Mental Health America of Wisconsin
Kelsey Hill	Department of Corrections
Teresa Steinmetz	Department of Health Services