

ROAD TO RECOVERY

Improving substance use disorder services in Milwaukee County



WISCONSIN
POLICY FORUM

ABOUT THE WISCONSIN POLICY FORUM

The Wisconsin Policy Forum was created on January 1, 2018, by the merger of the Milwaukee-based Public Policy Forum and the Madison-based Wisconsin Taxpayers Alliance. Throughout their lengthy histories, both organizations engaged in nonpartisan, independent research and civic education on fiscal and policy issues affecting state and local governments and school districts in Wisconsin. WPF is committed to those same activities and that spirit of nonpartisanship.

PREFACE AND ACKNOWLEDGMENTS

This report was undertaken to provide Milwaukee County Behavioral Health Services (BHS), local elected officials, community-based and private providers, other stakeholders, and citizens with a better understanding of the substance use disorder (SUD) service delivery landscape in Milwaukee County. The intent also was to lay out service gaps and opportunities for future investment in light of Milwaukee County's receipt of tens of millions of dollars from national legal settlements pertaining to opioids.

Report authors would like to thank officials from BHS, as well as the dozens of leaders from community-based SUD provider agencies and private health systems that we interviewed during the course of our research, for their assistance in providing information and for patiently answering our questions.

Finally, we thank BHS for commissioning and underwriting a substantial portion of this research, as well as Advocate Aurora Health for its generous grant that also supported the cost of this project.



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Milwaukee County*

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INTRODUCTION

The challenges associated with alcohol and substance use disorders in Wisconsin and Milwaukee County are well-documented and severe. With regard to alcohol, according to the Wisconsin Department of Health Services (DHS), Wisconsin [ranked third](#) in the nation in 2019 in the percentage of adults who said they had engaged in binge drinking in the past month (21.9%). Meanwhile, Wisconsin Policy Forum research has shown recent [increases in alcohol-related driving deaths](#) in Wisconsin during the pandemic and in total alcohol-related deaths [over the last two decades](#). In Milwaukee County, alcohol was the cause of 63.2 deaths per 100,000 residents from 2014-2019, well above the statewide average of 49.

The situation is equally alarming when it comes to other forms of substance use disorders. According to DHS, between 2014 and 2020, Wisconsin had [6,845 drug overdose deaths](#). Most involved opioid overdoses (5,338), but multi-drug overdoses (some of which included opioids) were the second most common cause of deaths in that period (3,101), followed by heroin, cocaine, and methamphetamines. Also, it is important to note that fentanyl – a highly dangerous synthetic opioid – has become a leading cause of overdose deaths, and it is often ingested unknowingly when it is mixed with other drugs.

DHS also reports that [opioid deaths](#) increased from 10.9 per 100,000 residents in 2014 to 21.1 in 2020. In Milwaukee County, the opioid death rate was a staggering 44.6 per 100,000 residents that year.

Milwaukee County's Behavioral Health Services (BHS – formerly known as the Behavioral Health Division, or BHD) has led efforts to combat substance use disorders in the county for decades, serving as both a direct service provider and as a coordinator of services provided by dozens of community agencies. BHS' Community Access to Recovery Services (CARS) program manages the division's wide range of integrated mental health and substance abuse services, administering a full array of supportive and recovery-oriented services to more than 10,000 Milwaukee County residents each year.

But BHS is not alone. Several major health systems provide a range of substance use disorder (SUD) services in the county, and the opioid challenge also has emerged as a priority for several of the county's 11 municipal health departments, emergency medical service providers, and a range of health care-related entities and community organizations that fall outside of the CARS umbrella.

BHS now has an opportunity to fortify its programming and amplify its leading role in the overall county-wide effort to effectively address SUD prevention, treatment, and recovery. Wisconsin stands to receive [more than \\$400 million](#) as part of a national legal settlement related to opioid abuse with several major drug distribution and manufacturing companies, and Milwaukee County expects to receive more than \$70 million from those payments. The county also may be able to access significant funding amounts to support its SUD programming from other new federal sources, including the federal Medicaid program.

REPORT TIMING

The research for this report was conducted from March through mid-September, 2022. Consequently, any changes to BHS' SUD fiscal or programmatic policies that were included in the county executive's 2023 recommended budget in late September are not taken into account in this report. Any such changes would need to be approved by the Milwaukee County Board of Supervisors in the adopted budget, which as of the time of this publication had not yet occurred.



To ensure that these substantial infusions of federal and state resources are spent wisely and effectively, BHS leaders approached the Wisconsin Policy Forum in late 2021 for assistance in enhancing understanding of the SUD provider landscape in the county – both for itself and for other stakeholders and the general public.

The Forum is well-equipped to provide such assistance. Our 2013 report, [Assessing the Financial Outlook of Milwaukee County's Behavioral Health Division](#), analyzed BHS' finances as the county prepared to redesign its mental health services and respond to the opportunities provided by the Affordable Care Act (ACA). We have also co-authored a series of reports to provide independent perspective on the county's mental health and SUD programming, including a landmark 2010 mental health redesign [report](#) and subsequent follow-up studies on [outpatient capacity](#) and [crisis services](#).

In this report, we seek to provide greater clarity on the SUD service provision landscape in the county with an eye toward identifying service gaps and priorities for new investment. We conducted dozens of interviews with officials and staff from BHS, community-based providers that are part of its service network, private health system leaders, and other stakeholders. Using these extensive interviews and review and analysis of comprehensive data received from BHS and providers, we conclude by sharing a series of insights that we hope will provide guidance to BHS and its partners as they seek to forge a more robust response to SUD challenges in Milwaukee County.

WHAT IS THE OPIOID SETTLEMENT?

The opioid settlement provides \$26 billion nationwide to resolve litigation related to the damages caused by opioid misuse. The litigation was filed by states and local governments and subdivisions against the three largest pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and a large manufacturer (Janssen Pharmaceuticals, Inc.) and its parent company, Johnson and Johnson. The settlement agreement follows three years of negotiations to resolve more than 3,300 claims across the country. Fifty-two states and territories, as well as thousands of local governments, have signed on to the agreement.

In February 2022, Wisconsin Attorney General Josh Kaul announced approval of the opioid settlement agreement for the State of Wisconsin. In Wisconsin, 87 litigating political subdivisions signed on to the agreement, which will lead to more than \$400 million in settlement payments. Out of that, Milwaukee County is expected to receive \$71 million. Collaboration between local governments and with the state is encouraged.

Payments from the distributors are beginning in 2022 and will continue over 18 years. Johnson and Johnson payments will continue for nine years. Under 2021 Wisconsin Act 57, 30% of the monies will be allocated to the Wisconsin Department of Health Services while the other 70% will be allocated to political subdivisions. Under this act, the money may not be used to substitute for budgeted funds from other sources and cannot be commingled with other funds.

<https://docs.legis.wisconsin.gov/2021/related/acts/57>

The settlement monies are intended specifically for opioid abatement efforts (as opposed to alcohol and other drugs). A list of pre-approved uses for the settlement funds developed with national public health experts allows for a range of intervention, treatment, education, and recovery services (additional details can be found [here](#))



MILWAUKEE COUNTY SUD SERVICE OVERVIEW

Milwaukee County Behavioral Health Services (BHS) administers a variety of community-based mental health and substance use disorder (SUD) services for adults with behavioral health needs in the county. These services are housed in the division’s Community Access to Recovery Services (CARS) system. According to county budget documents, CARS “is committed to fostering independence, choice, and hope for individuals by creating an array of services that are person-centered, recovery oriented, trauma informed, and culturally intelligent.”

Through a network of providers, CARS specializes in helping connect individuals who are at or below 200% of the poverty level with resources needed to guide and support recovery. In some cases, such as detoxification services, CARS serves individuals regardless of income level, but nearly all of its focus is on low-income individuals and particularly those who do not have any form of private or public health insurance.

CARS’ annual budget for SUD services is nearly \$12 million and is supported by annual funding from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), block grants from the State of Wisconsin, locally generated or allocated revenue (primarily property tax levy),¹ and several other smaller grant funding sources. **Table 1** shows the various funding sources that supported the CARS budget in 2021.

Table 1: CARS spending by funding source, 2021

Grant Name	Amount	Funding Source
Temporary Assistance for Needy Families (TANF)	\$3,479,015	Federal/State Pass-Through
Substance Abuse Prevention and Treatment Block Grant (SABG)	\$2,400,000	Federal/State Pass-Through
Substance Abuse Prevention and Treatment Block Grant Supplemental (SABG)	\$1,047,994	Federal/State Pass-Through
Intravenous Drug Use	\$532,221	Federal/State Pass-Through
Intoxicated Driver Program	\$499,636	Federal/State Pass-Through
AODA Inner City Services	\$24,016	Federal/State Pass-Through
Medication Assisted Treatment Expansion (MAT)*	\$165,134	Federal/State Pass-Through
Unmet Needs SOR	\$1,484,956	Federal/State Pass-Through
Division of Milwaukee Child Protective Services (DMCPS)	\$591,395	State
Adult Drug Treatment Court (ADTC)	\$365,781	Federal
Family Drug Treatment Court (FDTC)*	\$370,920	Federal
Property Tax Levy	\$939,446	Local
TOTAL	\$11,900,514	

* Signifies a funding source that will sunset by the end of 2022.

Notably, about \$11 million of the \$11.9 million spent under CARS in 2021 was supported by federal and state grants or pass-through monies, as opposed to local dollars. This reflects, in part, a long-time informal county policy to limit local spending on SUD services given that these services are not mandated by state government. The funding mix is significant because, as we will discuss later in

¹ In addition to receiving a portion of the county’s property tax levy, BHS receives a share of the county’s annual allocation of Basic Community Aids (BCA) from the state. These funds must be used for certain social services – including SUD services – and the funds are essentially commingled with BHS’ property tax allocation and directed to services at the discretion of county and Milwaukee Mental Health Board leaders within the BHS budget. Because it is impossible to distinguish between the use of property tax levy and these discretionary BCA funds, we simply refer to property tax levy in this report when describing locally-generated and locally-allocated resources.



this report, certain sources of SUD grant funds are limited to certain populations, thus restricting BHS' ability to allocate its resources as it might otherwise see fit.

A recent change in CARS' role

Historically, through its network of providers, CARS contracted directly with community-based providers for SUD services targeted for the uninsured. Those providers billed the county and were reimbursed per a contractual rate. However, the passage of the Affordable Care Act greatly expanded insurance coverage, thus substantially reducing the number of clients who lacked any form of insurance. Also, a recent change in federal and state policy now allows for Medicaid reimbursement for residential SUD treatment, which means that CARS providers of those services now bill Medicaid and other insurance companies themselves for most SUD clients.

These funding changes have dramatically altered the landscape in which CARS operates. With the expansion of insurance coverage, CARS now directly pays for fewer services and instead focuses more on the development of an appropriate network of providers to whom it can refer clients, as well as coordination and oversight of services. CARS funds coordination and oversight both for individuals who are seeking to access services for the first time and those who need help navigating treatment and recovery options after services commence.

This new paradigm has benefited BHS by freeing up additional resources and reducing its fiscal and administrative responsibilities. However, one concern is that BHS no longer has as strong a sense of the capacity needs and challenges of providers within its network and the availability of beds or treatment slots among various providers. For example, waitlists for residential treatment services were once maintained by BHS, but they are now in the hands of individual providers. Another concern is that the resources that have been freed up – such as those from the federal Temporary Assistance for Needy Families (TANF) program – are restricted to certain populations (in this case, women and men with children).

CARS is still responsible for directly paying for several types of services for clients at or below 200% of the poverty level who remain uninsured. In addition, there are Medicaid-funded services for which CARS still plays a supporting financial role, including residential treatment, which CARS supports by paying the cost of room and board (but not treatment, which is billed directly to Medicaid). Those room and board costs typically cannot be financed with TANF or other federal grant dollars, which means the use of scarce property tax dollars in this area has grown. Finally, BHS does not screen for income levels for clients it refers to detoxification services, which means that it pays most of the costs associated with those services with either property tax levy or grant resources, with the latter source becoming more prominent in recent years.

Table 2 contains brief summaries of the primary services administered by CARS and the providers who offer these services as part of BHS' service delivery network. The providers cited are primary providers of these services; others may also provide some elements of the services listed.



Table 2: Summary of CARS services

Service	Description	Providers
Access Point	Determines eligibility, administers a comprehensive screen, establishes a clinical level of care, makes a referral to treatment providers	IMPACT, Sirona Recovery, WestCare Wisconsin, United Community Center (UCC), Wisconsin Community Services (WCS)
Care Management	<ul style="list-style-type: none"> Recovery Support Coordination (RSC): helps client form a Recovery Support Team (RST) consisting of both formal and informal/natural supports AODA Targeted Case Management: assists recipients to gain access to and coordinate a full array of services including assessment, case plan development, and ongoing monitoring and service coordination 	<p>RSC: La Causa, Sirona Recovery, St. Charles, UCC, WCS</p> <p>AODA TCM: Alternatives in Psychological Consultation (APC), La Causa</p>
Clinical	<ul style="list-style-type: none"> Day Treatment: medically monitored, non-residential treatment service consisting of regularly scheduled sessions of various modalities (i.e., individual and group counseling and case management); provided under the supervision of a physician Medication Assisted Treatment (MAT): management and rehabilitation of narcotic addicts using methadone or other FDA-approved narcotics Outpatient non-residential services totaling less than 12 hours of counseling per patient per week, providing a variety of evaluation, diagnostic, crisis and treatment services 	<p>Day Treatment: Meta House, Services to Maintain Independence & Life Efficacy (S.M.I.L.E.), UCC</p> <p>MAT: Community Medical Services (CMS), Outreach Community Health Center</p> <p>Outpatient: AMRI Counseling Services, APC, AIDS Resource Center of WI, Access Recovery Mental Health Services (ARMHS), Effective Counseling, Guest House, Lutheran Counseling-Family Services, Lockett, Meta House, Outreach Community Health Centers, S.M.I.L.E., Sebastian Family Psychology, UCC, WCS, Word of Hope</p>
Clinical Short-Term Residential	<ul style="list-style-type: none"> Medically Monitored Residential (MMR) Outpatient Plus 	<p>MMR: Genesis Behavioral Services, Matt Talbot Recovery Services, Meta House, UCC</p> <p>Outpatient Plus: WCS</p>
Detoxification	<ul style="list-style-type: none"> Medically Monitored Residential Detoxification: 24-hour service for individuals in an acute and potentially dangerous state of withdrawal Residential Intoxication Monitoring: 24-hour residential observation for patients who are not in need of emergency medical or psychological care 	Matt Talbot
Employment	Rehabilitation Support Services -Employment	Goodwill, Standard of Excellence
Peer Support	Rehabilitation Support Services - Psych Self-Management	Effective Counseling, Great Lakes Dryhooch, Our Space, Sirona Recovery
Short-Term Residential (Bridge Housing)	Rehabilitation Support Services - Housing	4 th Dimension, Meta House, Our Safe Place (and Project Heat), Samad's House



Comprehensive Community Services (CCS)

The vast majority of SUD clients served by BHS receive their services via a CARS referral in the categories of services outlined above (4,253 such clients in 2021). A much smaller number (317 in 2021) are served under the CCS program, which provides a wider range of clinical and non-clinical services that address the holistic needs of clients and support them in improving their overall quality of life. CCS is available to consumers requiring both mental health and SUD services, but the vast majority of those currently enrolled in the program receive only mental health services (1,879 of the 2,196 program enrollees in 2021). CCS providers must be specifically credentialed by BHS.

CCS utilizes consumer-directed service plans to establish individualized goals and desired service interventions. The program uses a care coordination model, which according to BHS means “that a Care Coordinator is designated to provide service linkage and oversight, crisis prevention, and ongoing review of the consumer’s needs. The Care Coordinator and consumer meet at a frequency that is jointly agreed upon by both the Care Coordinator and the consumer...to support the recovery planning process and assess the consumer’s level of satisfaction with their services, as well as their progress toward their identified goals.”

SUD services provided under the CCS program include several of the services outlined above for other SUD clients served by CARS, including various clinical services like rehabilitation and treatment, medication management, and psychotherapy. However, other types of non-clinical services – like individual skill development, service planning, wellness, and employment – are much more common under CCS.

There is also some overlap in the CCS and regular SUD provider network, including agencies like WCS, Sirona Recovery, Guest House, and Meta House. A full list of CCS providers is provided later in this section.

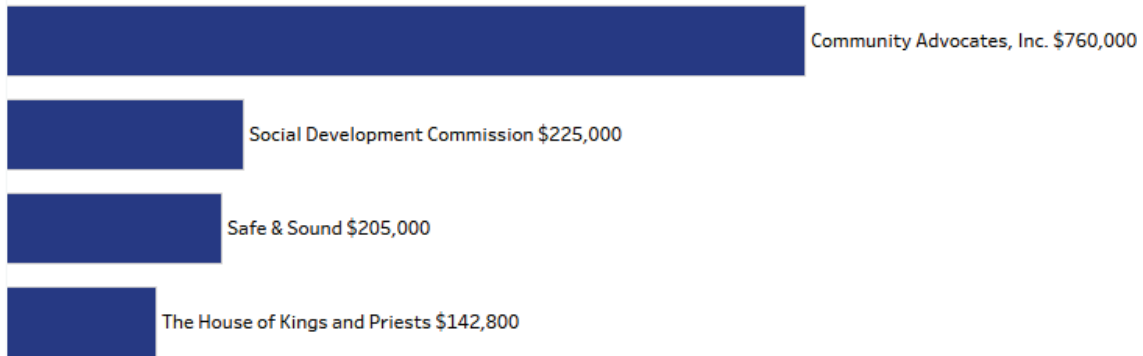
Other SUD services

In addition to these direct services, CARS is involved with other initiatives such as prevention and harm reduction.² A minimum of 20% of BHS’ Substance Abuse Prevention and Treatment Block Grant funds provided by the state as a pass-through of federal resources must be spent on prevention (though BHS officials say they spend more). CARS contracts with four different providers in Milwaukee County for prevention services, as shown in **Figure 1**, and spent \$1.3 million on those contracts in 2021. BHS also employs a prevention coordinator and added a second staff member to focus on prevention in the summer of 2022.

² [SAMHSA](#) defines harm reduction as “an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.”



Figure 1: BHS Prevention Contracts, 2021



Aside from prevention contracts, CARS gives \$150,000 annually to Oxford House, International to support the development and maintenance of a specialized network of residential housing in Milwaukee. The Oxford House model promotes “democratically run, self-supporting, and drug-free” homes, according to its website, that typically house six to 15 individuals. The model supports houses for men, women, and women with children.³ BHS officials say there are now at least 10 such houses in the Milwaukee County area and the program is expected to continue to grow.

Finally, BHS allocates some substance abuse funds to a training contract with St. Charles Youth and Family Services that seeks to provide high-quality training on a variety of best and evidence-based practices to the CARS provider network. The 2021 contract amount was \$350,000.

³ More information on the model can be found at <https://www.oxfordhouse.org/>



BHS' SUD OPERATIONAL FRAMEWORK AND SERVICE POPULATION

As noted in the previous section, BHS' traditional focus when it comes to SUD services is geared toward low-income Milwaukee County residents, with a specific emphasis on individuals who lack any form of health insurance. Milwaukee County residents seeking SUD services who have private health insurance typically receive them from private health systems and other providers who are not part of BHS' service network.

A primary way in which individuals gain access to BHS-funded services is through an Access Point location in the community. Those seeking SUD treatment come to Access Point locations in several ways. Some approach BHS or an Access Point provider themselves (or a family member does so) to request services; while others are referred to an Access Point location by another service provider (including private hospital emergency rooms) from whom they have requested assistance. Some are also referred after a call to the county's 211 phone line (run by IMPACT, which is a major provider of Access Point services in BHS' network). It also should be noted that BHS has its own intake team that focuses mostly on individuals with mental health needs but also screens and refers individuals with co-occurring or substance use disorders.

Access Point locations conduct screenings that include an assessment of the client's insurance coverage and ability to pay. Those who have private health insurance typically are referred to their insurance company's navigator service.

An exception to this typical process involves individuals who are in need of immediate intervention and require detoxification services.⁴ In that case, they may physically present at Matt Talbot, the BHS-funded detox provider (or be brought there via a family member or other party), or they may be physically transported to such a location by law enforcement. Detox services are provided and billed to BHS regardless of income or health insurance status, though BHS' financial involvement with follow-up services upon discharge likely will be limited to those who lack health insurance.

How many people does BHS serve and how does it serve them?

One of the important objectives of this study was to gain greater insight into the volumes and characteristics of individuals served by BHS through its SUD service reimbursements and how those services are being provided. It was our hope that by quantifying answers to those questions and comparing BHS' service population and services to those of major providers outside of the BHS service delivery network, we would be able to identify overall service gaps that exist within the county and opportunities for enhanced investment.

Unfortunately, determining who is being served by BHS and its provider network and what types of services they are receiving is not as simple as it sounds. That is because while BHS is able to precisely track individuals and the services they receive when BHS pays for the service, it does not track services for individuals who are referred to a provider in BHS' network through Access Point when the provider bills Medicaid directly for those services. As we will discuss, that eliminates our

⁴ The American Psychological Association defines detoxification as "a therapeutic procedure...that reduces or eliminates toxic substances (e.g., alcohol or opioids) in the body...In many cases, detoxification occurs in a clinic, hospital unit, or residential rehabilitation center devoted to treating individuals for the toxic effects of alcohol or drug overdose and to managing their acute withdrawal symptoms" (<https://dictionary.apa.org/detoxification>).



ability to pinpoint all of the SUD services received by individuals whose connection to those services may have originated via Access Point.

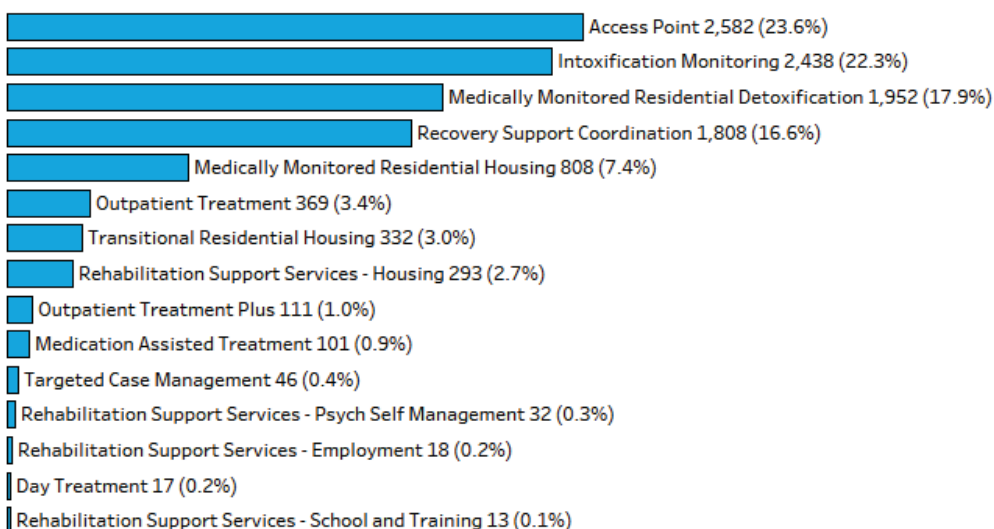
Nevertheless, we were able to use data provided by BHS to paint a picture of the number of individuals who touched the BHS provider network in 2021 and – for those services paid by BHS – the volume and nature of services they received. Because of the previously mentioned change in Medicaid billing policy that occurred last year, this does not include costs for most treatment received in residential settings (which is now billed directly to Medicaid by providers), and it eliminates our ability to conduct trend analysis using data from previous years. Also, because the Medicaid change occurred early in 2021, the 2021 data do not reflect what a full year would look like.

Service volumes

We began our analysis by examining service volumes for BHS’ regular Alcohol and Other Drug Abuse (AODA) services provided under CARS (the far smaller SUD service volumes involving consumers enrolled in CCS are covered later). As shown in **Figure 2**, we find that BHS’ Access Point providers experienced the highest service levels in 2021, with 2,582 “episodes” (i.e. service occurrences). This is not surprising given that Access Point is the entrance point for most clients into CARS and other services provided typically flow from that initial encounter.

Intoxication Monitoring was close behind with 2,438 episodes. This is a form of detoxification defined by DHS as a residential service providing “24-hour per day observation by staff to monitor the safe resolution of alcohol or sedative intoxication and to monitor for the development of alcohol withdrawal for intoxicated patients who are not in need of emergency medical or psychological care.”⁵ Medically monitored detoxification – a treatment for individuals whose symptoms of withdrawal are acute and potentially dangerous that involves the use of medications to ease the process of detoxification – was third with 1,952 episodes.

Figure 2: Number of episodes by type of service used, BHS AODA patients in 2021



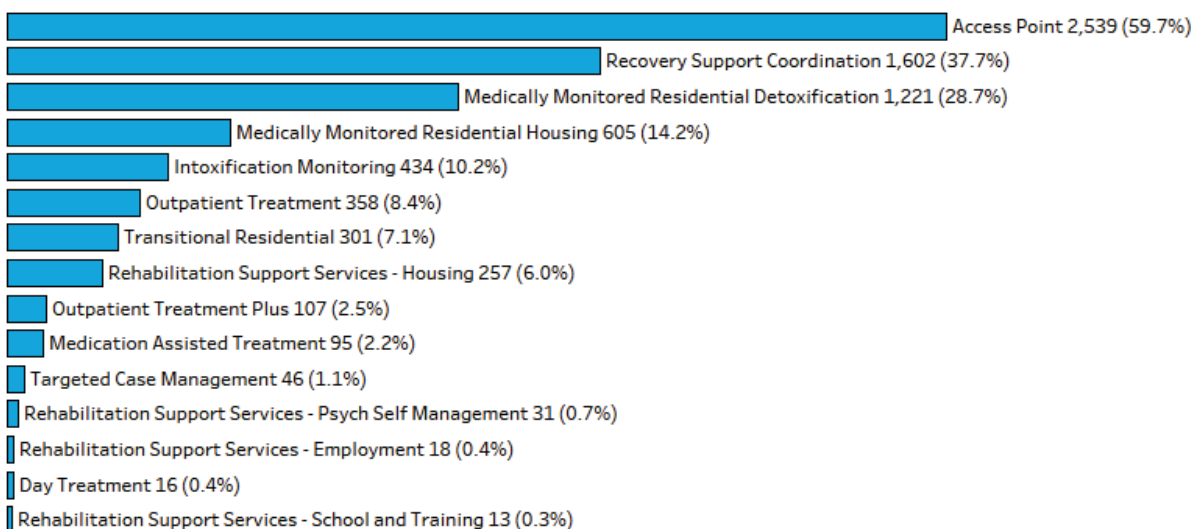
⁵ Found at <https://www.dhs.wisconsin.gov/regulations/aoda/residential-intox-monitor.htm>.



This breakdown shows that more than three-fifths (63.8%) of the episodes involving BHS payment in 2021 involved either initial screening and referral through Access Point or detoxification for individuals needing help for an immediate SUD occurrence. Far fewer services paid by BHS involved longer-term, community-based, recovery-oriented services, such as Recovery Support Coordination (RSC – 16.6% of all service episodes) and various forms of residential and outpatient treatment.

A different way of analyzing CARS service data involves the number of individuals using each service, as opposed to the number of episodes for each (an individual could obtain treatment for several service episodes in a given year). As shown in Figure 3, the results in terms of services received do not look dramatically different, although RSC jumped to second on the list and medically monitored housing rose to fourth. It should be noted that the total number of individuals served by CARS through its regular AODA services (i.e. not CCS) was 4,253, which is less than the total shown in the figure because individuals may receive multiple services.

Figure 3: Number of individuals using each service in 2021, BHS AODA patients



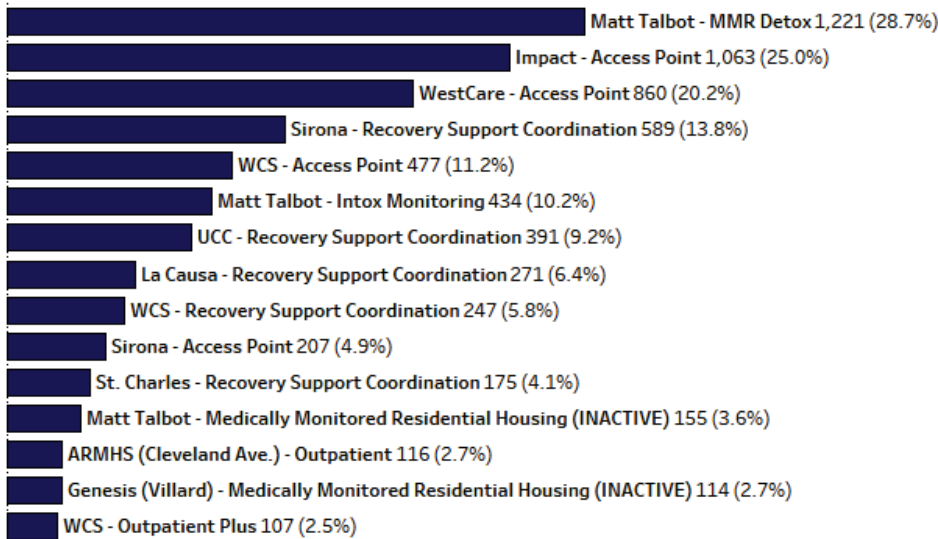
As with the previous figure, this depiction of CARS-funded services shows that BHS' foremost role is to administer detoxification and initial screening and referral. Sizable numbers of individuals also receive CARS-supported recovery support coordination but far fewer receive other forms of rehabilitation and recovery services that are financially supported and tracked by BHS.

Providers in the CARS AODA network

The CARS service provider network includes dozens of community-based organizations, including several that provide multiple types of services and others that focus on a single service area. Figure 4 shows the CARS service providers that served 100 or more consumers in 2021 in the service categories shown in earlier figures. Some providers – like Matt Talbot, WestCare, Sirona Recovery Services, and Wisconsin Community Services – appear in multiple service categories.



Figure 4: Top providers by number of individuals using them, BHS AODA patients in 2021



Includes all provider/service combinations with at least 100 individuals having used them in 2021. INACTIVE indicates that at the time the query was run, the provider was no longer active in the system.

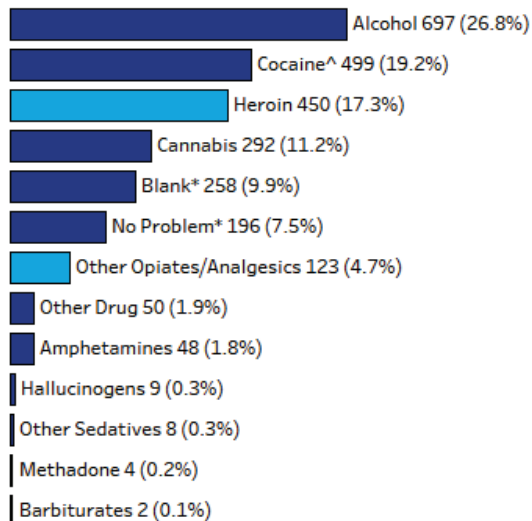
As noted above, Matt Talbot is the sole provider of detox services in the CARS network. Users of Access Point were relatively evenly divided between IMPACT and WestCare, with WCS and Sirona Recovery also serving significant numbers of individuals for that service.

Primary substance of abuse for those served by CARS

We also asked BHS to give us a sense of the types of substances that were most prominent in terms of being the “primary substance of abuse” (this is the term used by BHS) for its service population in 2021. The primary substance is generally defined as the substance used most frequently during the previous 30 days. It is important to note that many individuals served by BHS reported use of multiple substances.

Figure 5 shows that alcohol and cocaine were the two substances cited most frequently as the primary substance of abuse and constituted a near majority with a combined 46% for the 2021 service population. Heroin and other opiates were the primary substance for 21.8% of the 2021 service population. As we will discuss in later sections, this finding is consistent with the observations of providers in the BHS service network,

Figure 5: Primary Drug of Abuse, 2021 AODA Individuals**



*“Blank” or “No Problem” indicates an individual who indicated no recent drug abuse issues.

**Some double counting included for individuals with multiple diagnosis events over the course of 2021.

^Includes crack cocaine.

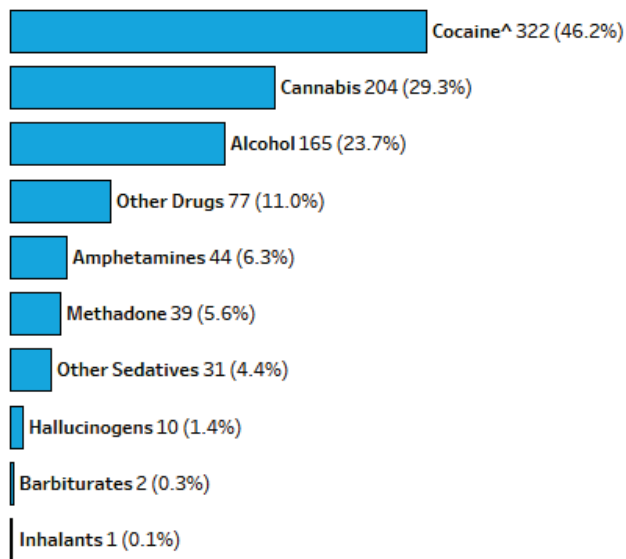


who cited substance use disorders associated with alcohol, cocaine, and cannabis (which was the primary substance for 11.2% of BHS clients in 2021) as being collectively more frequent than those associated with opioids for the individuals they serve.

The BHS data also allowed us to explore, for those who did cite opioids as their primary substance of abuse, the extent to which they reported co-occurring use of other substances. As shown in **Figure 6**, substantial percentages of that population in 2021 cited the co-occurring use of cocaine, cannabis, and alcohol.

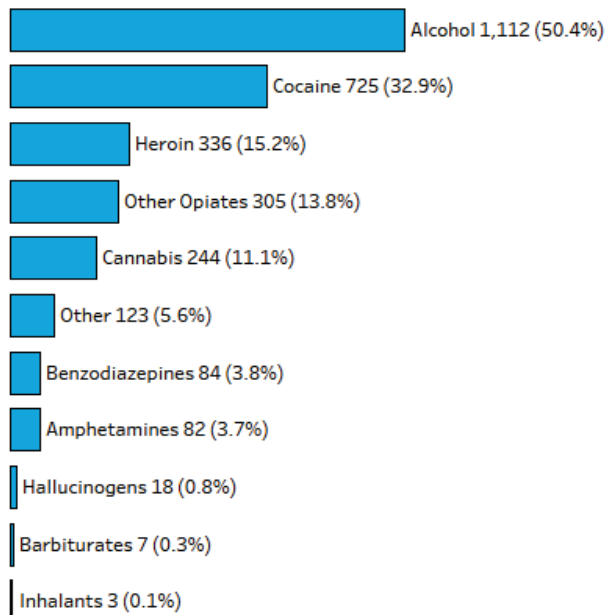
We also received data on specific substances from IMPACT, which not only is the largest CARS-funded Access Point provider, but also runs the county's 211 line for those seeking assistance with various social services-related issues. The IMPACT data allow us to gain additional perspective on the predominance of different substances among those who seek SUD services in Milwaukee County. As shown in **Figure 7**, alcohol was cited by just over half of the 2,207 callers who reported substance use in 2021, while cocaine was cited by about a third. Use of heroin or other opiates was cited by 29%. These responses are consistent with the finding from the CARS population that alcohol is the most commonly used substance, with cocaine second and heroin third.

Figure 6: Co-Occurring Drug Use Among 2021 AODA Individuals Who Indicated Any Heroin or Other Opiate Use (out of 697 total)



[^]Includes crack cocaine.

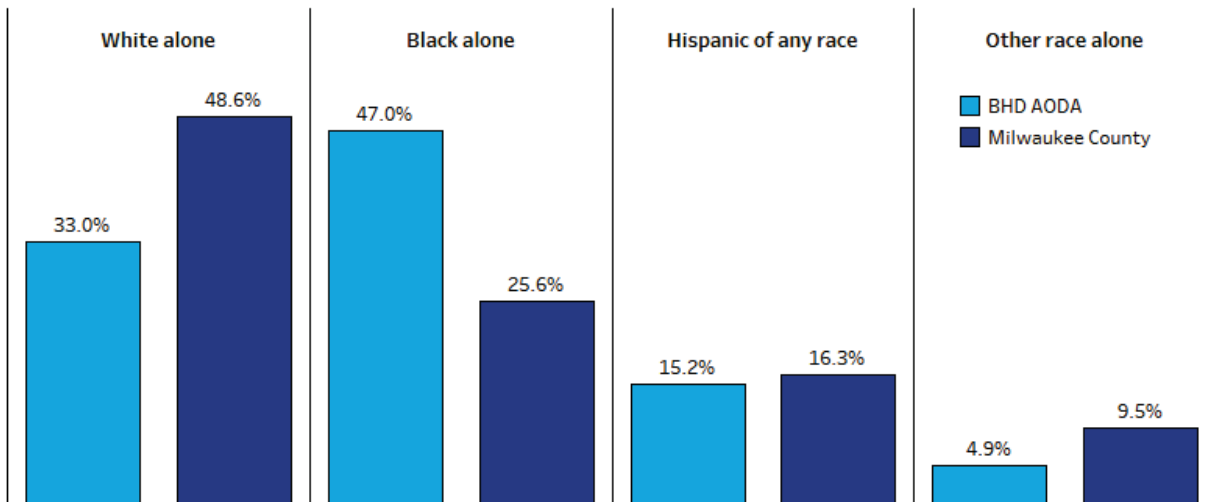
Fig 7: Total Substance Use Reported via 211 Calls in 2021
Of 2,207 callers that answered "can you tell us what substance(s) you are using?"



Demographics of individuals served by CARS

The BHS data also provide insight into the race and age of individuals who received CARS-funded services in 2021. **Figure 8** shows that Black individuals comprised the largest share (47.0%) of the CARS AODA service population in 2021, despite comprising just over a quarter (25.6%) of the population of Milwaukee County. About a third of the patients served were white, while whites make up 48.6% of the county's population.

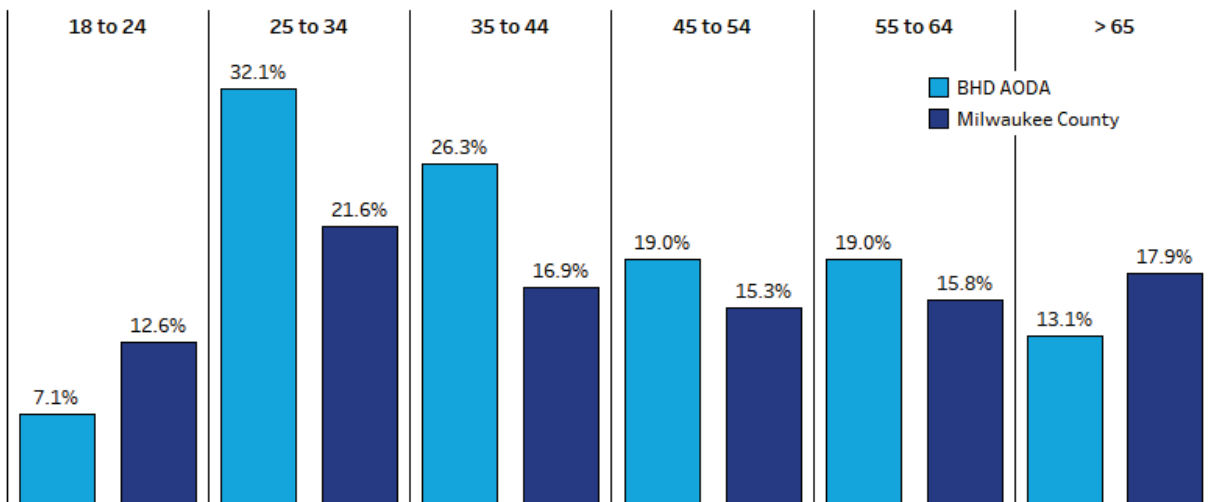
Figure 8: Race/ethnicity of 2021 BHS AODA patients vs. Milwaukee County residents



Source: U.S. Census Bureau Table P2 - 2020 Redistricting Data

Figure 9 breaks down the age of county residents served in 2021. It shows that residents between the ages of 25 and 34 were the most frequent service recipients at 32.1%, which was considerably higher than that age group's share of the overall county population (21.6%). CARS AODA services also were received by larger percentages of residents in the 35 to 44, 45 to 54, and 55 to 64 age groups than their shares of the overall population might have suggested, although not to the same degree as the 25 to 34 age group.

Figure 9: Age of 2021 BHS AODA patients vs. Milwaukee County residents

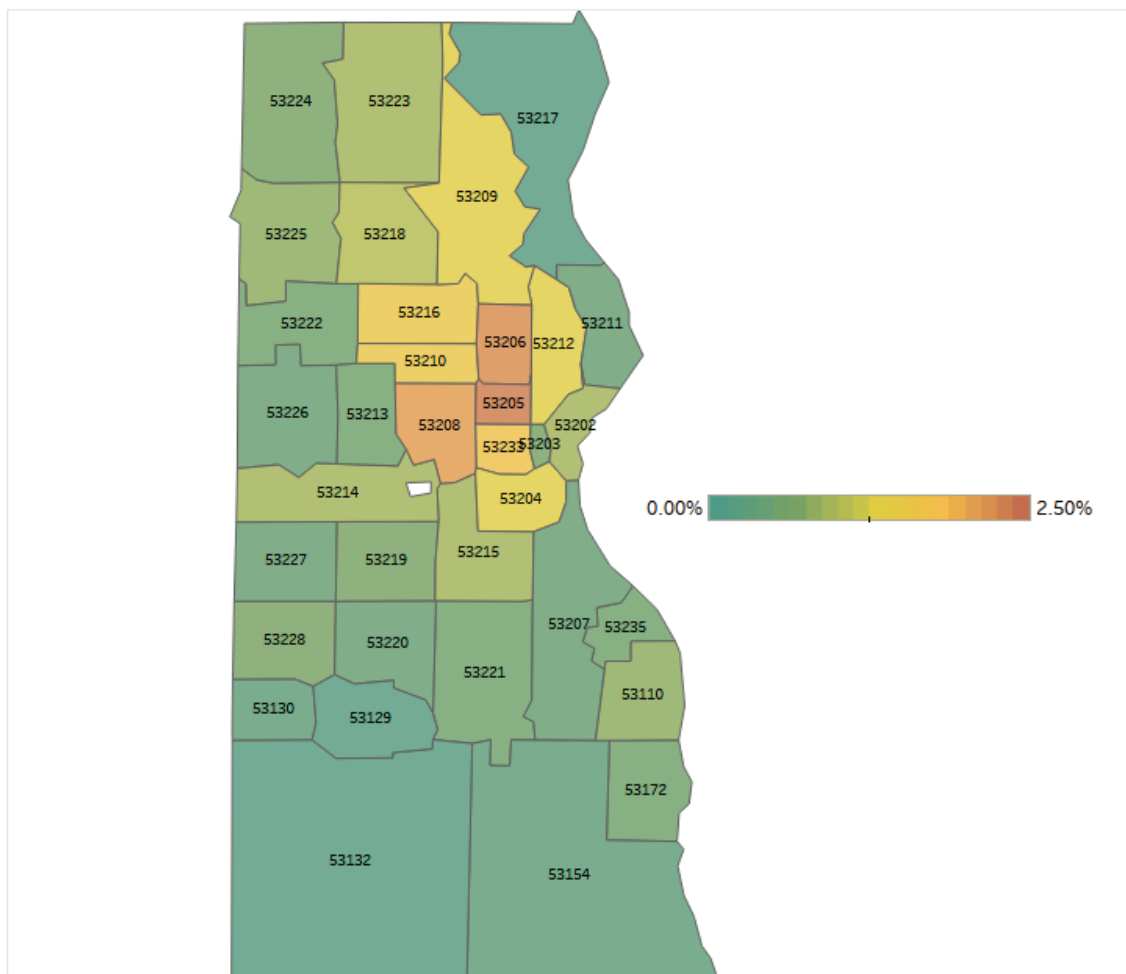


Source: U.S. Census Bureau, Table S0101, 2020 5-Year ACS Data. Milwaukee County Population = as a % of those 18 and older.



Finally, while we were not able to easily break down the CARS data by geographic location, 211 call data from IMPACT allows us to get a sense of which ZIP codes in the county saw the highest percentages of residents seeking SUD services via the 211 line in 2021. As shown in **Figure 10**, the 53205, 53206, and 53208 ZIP codes were at the top of that list.

Figure 10: Percentage of Households That Called 211 for a Substance Use Issue in 2021
by ZIP Code



SUD services for those enrolled in CCS

As noted earlier, CCS is a Medicaid-funded program that provides a much broader array of both clinical and non-clinical SUD services than those offered under the CARS AODA service array. Individuals must elect to enroll in CCS – which requires frequent meetings with a care coordinator – and must meet eligibility requirements, including having a diagnosis of SUD and “a functional impairment that interferes with or limits one or more major life activities and results in needs for services that are described as ongoing, comprehensive, and either high-intensity or low-intensity.”⁶

In 2021, 317 individuals were enrolled in CCS for SUD services. Data provided by BHS for the CCS service population was in a different format than that provided for CARS AODA services. For CCS, we

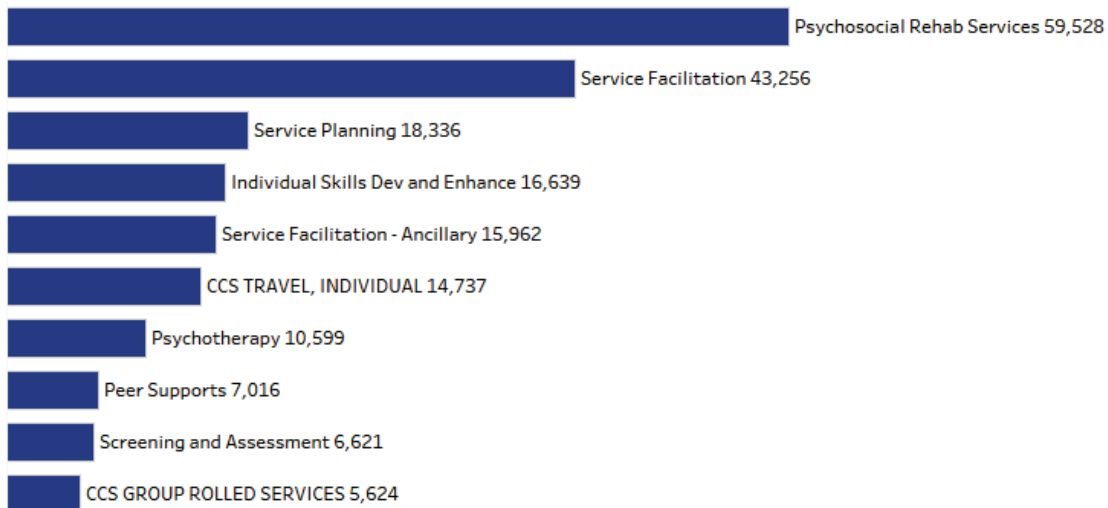
⁶ Wisconsin Administrative Code, [DHS Chapter 36](#).



received data that tracks units of service, which can be based on hourly amounts or other metrics. In a given year, one individual may use several units of service.

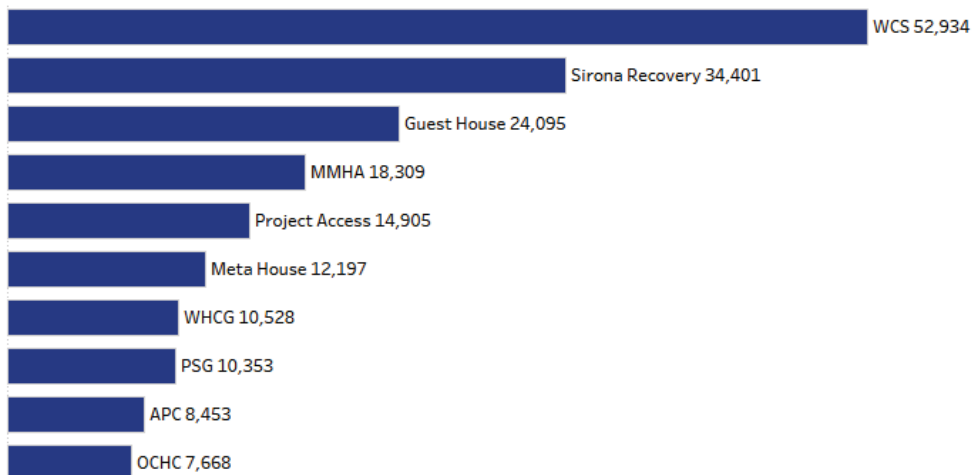
Figure 11 shows that the broad category of psychosocial rehabilitation services was the most extensively-used CCS service category in 2021, followed by service facilitation and service planning.⁷ Overall, the chart illustrates how CCS services differ from regular AODA services in their emphasis on holistic services like facilitation, planning, and skills development.

Figure 11: CCS Services by Units of Service 2021



As with the CARS AODA network, BHS maintains a network of providers who serve CCS enrollees (see **Figure 12**). Some, like WCS, Sirona Recovery, Guest House, and Meta House, participate in both.

Figure 12: CCS Providers by Units of Service in 2021

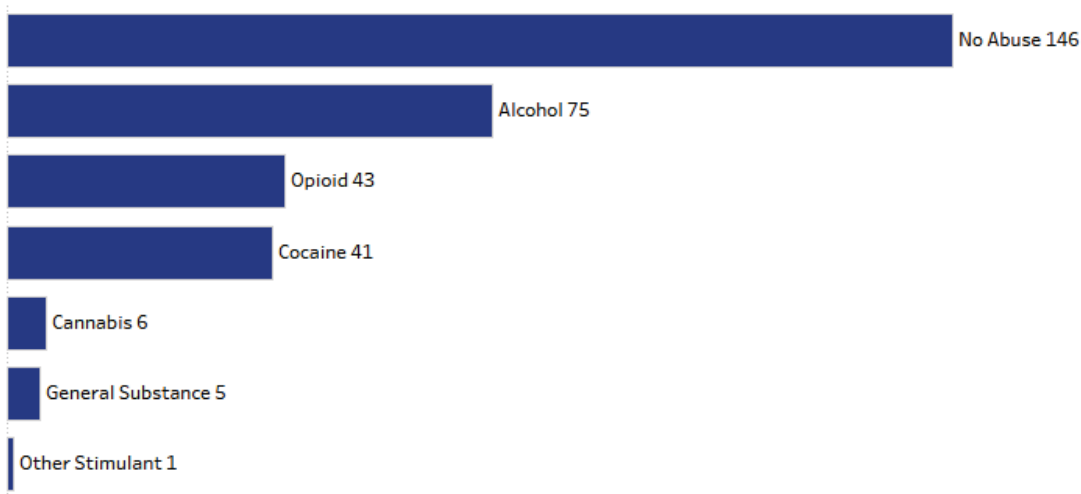


⁷ The data provided by BHS included 20,355 units of services coded as “non-covered services.” According to BHS staff, these are services that do not qualify for Medicaid/CCS reimbursement or that involve prescription drugs provided to patients before a prescription is in place, in which case tax levy must be used to pay for them. Because we could not distinguish between the types of services included in non-covered services, we did not include this category in the figure.



With regard to the primary substance of abuse for CCS enrollees, we see in **Figure 13** that almost half (46%) cited none (this likely reflects the perception of the client, who would not be enrolled in CCS SUD services unless diagnosed with an SUD). Of those that did cite a primary substance, alcohol was the most frequent with 75 (24%) while opioids were next with 43 (14%) followed closely by cocaine with 41 (13%).

Figure 13: Drug Use by CCS Patients with Substance Abuse Diagnosis or Receiving Substance Abuse Services 2021



We were also able to obtain demographic information on the individuals diagnosed with an SUD who were served by CCS in 2021. Those data show that Black individuals comprised a majority (56.2%) of the population served (white individuals were next at 38.8%), and that the population skewed older than the CARS AODA population, with a combined 60% of enrollees in the 45 to 54 and 55 to 64 age groups and only 13.6% in the 25 to 34 age group.

Summary and observations

This broad summary of BHS’ 2021 service population admittedly is limited, as it only reflects the services for which BHS is paying. Still, it provides some important insights into the nature and scope of BHS’ SUD services and provider network that have bearing on potential investment opportunities. Those include the following:

- **Initial screening/referral and detoxification services are both the gateway to publicly-funded SUD services in Milwaukee County and the primary services provided under the BHS umbrella** (representing 64% of all episodes of care for which BHS paid). While a much broader array of services is provided to those who are screened at Access Point locations or who enter through immediate detox needs, BHS no longer plays as big a role in administering and paying for those services, but instead now serves as more of a gateway to services. It still serves a substantial number of low-income county residents in this fashion, with more than 2,500 individual encounters at Access Point in 2021 and more than 1,500 at the county-funded detox provider.



- **BHS' changing role in SUD services has created a potential weakness in the system, in that BHS no longer has the ability to track many of the other services being provided to its clients and their journey to recovery.** This leaves a void in the system, as BHS cannot determine overall need based upon the number of services provided. It also cannot assess as readily where demand is not being met and waitlists exist, and where providers might better coordinate to more effectively serve client needs.
- **The BHS provider network – as defined by those receiving payments directly from BHS – is dominated by a relatively small number of community-based providers:** Matt Talbot, IMPACT, Sirona Recovery, WCS, and WestCare. We do not necessarily deem this a pro or a con, but it should make stronger coordination among these agencies an easier task if that is something BHS leaders wish to pursue, and it should make collection and analysis of performance data an easier task as well.
- The regular AODA services funded by BHS (outside of screening/referral and detox) include mostly recovery support coordination and smaller levels of outpatient and day treatment and case management. Meanwhile, those being served under CCS receive a broader range of services, including those that address social determinants of health like employment and transportation. However, **far fewer individuals (317 in 2021) are being served for their SUD under CCS than under the traditional AODA service array (4,253).** BHS officials point out that because CCS is designed for people who are on a path to recovery and are able to participate in and direct their own care, the program may not be the best fit for those in early stages of recovery. However, a greater emphasis on transitioning people to CCS as part of the path to recovery may be merited.

We also held several discussions with BHS officials and staff regarding these data findings and what they tell us. Important takeaways from those conversations include the following:

- 1) There is concern that individuals who gain entry into the BHS service network via a detoxification service are not necessarily receiving or benefiting from other follow-up services, but BHS is not able to track those individuals to confirm whether that is the case. Also, if an individual's first BHS contact is via detox, then that means potential opportunities to intervene earlier with individuals to address their treatment needs may have been missed.
- 2) BHS has largely lost its ability to track the imbalance between demand and supply of residential treatment – including for special populations like women with children – because of the switch to direct Medicaid billing by residential treatment providers, who now maintain their own waiting lists and field requests for housing directly. BHS officials note that some waitlist information is shared with them by providers, however.
- 3) It likely would be beneficial to expand the roster of individuals receiving SUD services under CCS, but providers have been unable to expand as quickly as BHS would like. This is in large part because of workforce challenges, but whatever the cause, BHS officials see unmet opportunities for increased CCS enrollment. Also, in light of the several days or weeks it takes to enroll people in the full array of CCS services, some may be discharged from detox or other services before that can occur. BHS officials feel there is opportunity to strengthen efforts to assist providers in using expedited CCS enrollment, as well as to encourage them



to take advantage of an “abbreviated assessment” that allows some services to be initiated immediately and to begin the enrollment process earlier in their clients’ treatment.

- 4) BHS is challenged by the restrictions attached to its various funding sources, which often prevent it from allocating resources to populations and services that are most in need. For example, the division’s single largest source of SUD funding in 2021 – TANF at \$3.5 million, or nearly 30% of all SUD funds – is restricted to use on low-income women and men with children. BHS officials feel they have sufficient resources to serve that population; in fact, BHS often struggles to allocate its TANF dollars, yet it lacks sufficient funding to serve single males.

In the next section, we review the results of our interviews with several providers in the BHS network to add context to the insights we gleaned from our analysis of BHS data.



BHS-AFFILIATED PROVIDER INSIGHTS

To gain additional perspective on BHS-administered SUD services, we conducted interviews with representatives from six prominent and longstanding participants in BHS’ SUD provider network: Guest House, IMPACT, Matt Talbot, Meta House, Sirona Recovery Services, and Wisconsin Community Services (WCS). We deliberately selected providers that participate in the largest service categories funded by BHS: detoxification (Matt Talbot), Access Point (IMPACT), residential (Meta House), and recovery support coordination (Sirona Recovery). We chose Guest House because it administers an SUD clinic and we felt they could offer important insight into the current demand for addiction treatment services; and we selected WCS because it is a substantial service provider in several categories, including Access Point, RSC, residential treatment, and CCS. Several of our other interviewees also provide several types of services in the BHS network.

While we were not able to obtain detailed programmatic, fiscal, and performance data for each of the providers we interviewed, we did access such information from three of the providers. We summarize their “stories” below as well as areas they identified that are most in need of additional investment as further context for our review of the SUD landscape in Milwaukee County.

Meta House

Meta House is a nonprofit organization dedicated to “ending the generational cycle of addiction by healing women and strengthening families.”⁸ According to the organization’s website, from its inception in 1963, Meta House has grown to serve up to 35 women and 15 children at a time in its residential treatment program, and has added robust outpatient and transitional housing programs. Combined, these programs served 350 women and 212 children in 2021.

Meta House Snapshot	
Annual Budget (2021)	Approx. \$7 million
Milwaukee County Funding	13%
State/Federal Funding	49%
Total Women Served (2021)	
Residential Treatment	178
Outpatient	264
Transitional Housing	89
Client Demographics (2021)	
Race	33% Black/50% white
Employment	71% unemployed
Annual Income	95% <\$20,000
Criminal Justice Involvement	84%

Meta House serves an important niche in the county’s SUD network as one of the primary agencies that provides “bridge” housing for women who suffer from SUD and their children. This form of housing is available for up to nine months for non-parenting women and one year for women with children residing with them as the client seeks more permanent housing. BHS reimbursement is its primary funding source, as this service is not eligible for Medicaid reimbursement. If the client seeks RSC services, then she is referred to an Access Point location; some are also encouraged to enroll in CCS.

Meta House’s residential treatment program involves intensive, 24-hour care that includes individual and group therapy, education on health and living skills, and parenting services. Some of the programming is conducted by certified peer specialists. As noted above, up to 35 women may be receiving residential treatment at any given point in time, and women may bring their children with

⁸ See <https://www.metahouse.org/about>.



them into the residential treatment setting. Fifteen of Meta House’s residential treatment beds are currently reserved for referrals from the Wisconsin Department of Corrections, with whom Meta House has a contractual arrangement to receive clients from across the state. The remaining 20 are for clients referred by BHS or health and human services agencies from other counties.

The agency says there is always a waitlist for its residential treatment that is typically in the range of 40 to 50 self-referred individuals. Officials say they receive minimal referrals from Access Points. According to agency officials, Meta House often refers women on its waitlist to outpatient treatment providers (including its own) to try to ensure that they are receiving some treatment while they wait. They also refer to the United Community Center (UCC), which is another primary residential treatment provider in BHS’ network, though they note that UCC also typically has a waitlist. Meta House staff also often contact BHS and suggest enrollment in RSC services for those waiting, but they suspect that many who are on their waitlist simply do not receive any form of service while they are seeking admission into residential treatment.

Meta House officials believe there is an immediate need for greater residential treatment capacity in the community. Meta House has plans to relocate its operations in the next 18 to 24 months, which will double its bed capacity from 35 to 70 beds. Officials also point to the need for more bridge and longer-term housing for families. They say this is a critical component of their continuum of care to further their clients’ path toward recovery. They also point out that they are one of the few providers that serves pregnant and postpartum women in the residential treatment setting and that greater bed capacity in that area would be beneficial, as well.

Another specific need cited by Meta House officials is enhanced reimbursement rates for services not covered by Medicaid that are essential to the agency’s mission and the individuals it serves. While Medicaid reimburses for certain “core” SUD services in the residential treatment setting, it does not provide reimbursement for services that are essential in a family-centered treatment setting like parenting assistance/coaching and supports for children. Officials say they rely on state and federal grants to offset those costs but the grants may not be long-term in nature.

In addition, while Milwaukee County reimburses for room and board costs associated with residential treatment for both women who are being treated and their children (these are not Medicaid-eligible), Meta House officials say the reimbursement rate of \$53 per person per day (recently increased by BHS from \$40) falls short of actual costs. The agency must raise outside dollars to pay for those unreimbursed costs.⁹

Other needs cited by Meta House officials include investments in information technology to allow BHS and providers to share information and improve billing efficiencies, as well as investments in workforce development, such as stipends for interns that would encourage them to work at nonprofit providers and pursue careers in SUD-related fields. As we will discuss below, those are sentiments expressed by other providers, as well.

IMPACT

IMPACT is a nonprofit social services provider that has served the metro Milwaukee area for more than 60 years. The agency’s SUD services include Access Point and other consultation and referral services, but not treatment. That said, SUD services have always been the backbone of the

⁹ The Wisconsin Department of Health Services has indicated that it will begin paying room and board costs with a portion of the state’s opioid settlement monies, but only for clients who are specifically suffering from an opioid-related SUD.



organization; in fact, it was formed as the “Council on Alcoholism” and its legal name is “IMPACT Alcohol and Other Drug Abuse Services, Inc.”

IMPACT also houses Milwaukee County’s 211 line – a confidential helpline that guides callers to appropriate social services – and it conducts planning and evaluation for other social services providers. Recently, the group also formed “IMPACT Connect,” an effort that, according to its website, “bring(s) together medical, behavioral health, social service, and community organizations to build an accessible and integrated delivery system.” According to its website, IMPACT had more than 380,000 contacts with individuals seeking services in 2020.¹⁰ It also assists roughly 10,000 individuals annually with AODA services.

IMPACT Snapshot	
Annual Budget (2020)	Approx. \$5.7 million
Milwaukee County Funding	23%
Other Government Funding	27%
Total 211 Contacts (2021)	369,636
Total Milw Co SUD 211 Contacts	3,730
Total Indivs Served by SUD Services (2021)	6,129
Milw Co SUD 211 Contacts Demographics (2021)	
Race	53% Black/32% white 56% Male/44% Female
Gender	45% 36 to 55/24% over 55/31% 18 to 36
Age	

As BHS’ largest Access Point provider (more than 1,000 individuals served in 2021) that is responsible for comprehensive assessment and referral to appropriate services, IMPACT’s leaders have a unique perspective on the overall service network in Milwaukee County. Similar to leaders at Meta House, they cite housing as the number one need for additional investment in the community. They not only echo the point about needing more bridge housing for families with children, but add that there is a need for more housing at all levels, including for single individuals in early recovery. They also note that the Housing First policy embraced by Milwaukee County works well for many in the homeless community, but it does not work as well for those in recovery because many of the units used to implement that policy do not require residents to be sober.

IMPACT leaders also expressed concern about the lack of a centralized waitlist for residential treatment services; as discussed above, BHS used to maintain a waitlist but no longer is able to do so in light of the change in Medicaid policy that allows providers to bill Medicaid directly. IMPACT leaders say that even though they are a primary source of assessment and referral, they do not know who has capacity and how many beds may be available in the community. They add that some individuals now go directly to residential treatment providers and bypass Access Point, which hampers efforts to coordinate and prioritize care for those who most badly need it.

One IMPACT leader also cited WCS’ Outpatient Plus program – which provides both transitional housing and outpatient care – as one that would benefit from additional investment. Linked to that comment is a similar one on the need for access to more peer supports – a service provided under Outpatient Plus – which is hampered by a lack of agencies in the county who provide peer support training. IMPACT leaders also cited a lack of coordination among the different types of SUD providers in the community, who specialize in their own areas of care but are not effectively connected to each other and therefore cannot effectively coordinate services and referrals.

¹⁰ See <https://www.impactinc.org/about-us/>.



IMPACT leaders shared some important perspective on the opioid crisis. While they acknowledge the severity of opioid use disorders, they still contest, as one leader put it, that “alcohol is always king” and note that many who abuse opioids started with alcoholism, and often at a young age. They also note that many opioid deaths in recent months are linked to individuals who are not opioid users, but who instead use cocaine that is laced with fentanyl without their knowledge. They add that marijuana laced with fentanyl is another growing problem.

Consequently, according to these leaders, public education efforts linked to opioids may not be as badly needed as they once were, and targeting prevention and education toward alcohol and other non-opioid drugs (including those that may be prone to being laced with fentanyl) may need to take on new prominence. Also, they feel that any move to target new residential treatment beds to opioid abusers may now be misguided, as progress has been made on the opioid front but remains lacking in terms of alcohol and other drugs.

Wisconsin Community Services

According to its [website](#), WCS was founded in 1912 as the “Society of the Friendless” with a primary mission of aiding men returning to the community from the corrections system. For much of its history it continued that primary focus on serving offenders, adopting the name of Wisconsin Correctional Services in 1966 and growing from a staff of 10 to more than 200 by 2003. In that year, the agency changed its name again to Wisconsin Community Services and expanded its mission to serve both individuals referred from the justice system and those with no connection to that system.

Today, WCS serves more than 14,000 individuals annually with a staff of more than 470 employees. The agency administers more than 50 programs for “individuals facing challenges with justice system involvement and behavioral health needs.” They are also the largest provider of peer services in Wisconsin.

With regard to SUD services, WCS has the broadest range of any of the organizations we interviewed and likely of any community-based provider in Milwaukee County. As shown earlier in this report, they are one of the primary BHS-funded providers of Access Point, Recovery Support Coordination, and CCS services.

In addition to being able to provide perspective on those programs, WCS leaders we interviewed also were able to share insights on three of its unique programs that may be excellent candidates for expansion via opioid settlement or other resources.

- *Sankofa House* is a transitional living facility that also provides outpatient treatment services under a model called Outpatient Plus. The facility can serve up to 12 men and six women at one time (serving a total of 106 individuals in 2021) and provides up to 90 days of transitional housing for those who are stepping down from more intensive residential treatment. WCS officials say they would welcome an expansion of the program to include more beds and the capacity to allow participants to stay for longer than 90 days.

WCS Snapshot	
Annual Budget (2020)	Approx. \$37 million
Milwaukee County Funding	51%
Other Government Funding	42%
Total Individuals Served (2020)	12,749
Total Served by SUD Services (2021)	3,058
Client Demographics (2020)	
Race	39% Black/44% white
Gender	69% Male/29% Female
Age	38% 35 to 54/12% over 55/41% 18 to 34



- *Hub & Spoke Health Home* is a program initiated about two years ago as a pilot with support from the Wisconsin DHS. As the hub, WCS provides care coordination and peer support for adults with substance use needs under a health home approach.¹¹ Participants receive services from the “spokes,” which are a network of service providers including health systems (Advocate Aurora, Ascension), federally qualified health centers (16th Street and Progressive community health centers), an addiction treatment center (Community Medical Services), and others. As of July 2022, there were 164 individuals enrolled in the program; the vast majority either had an alcohol use disorder (44%) or opioid use disorder (37%) as their primary substance of abuse. Again, greater capacity would be welcomed.
- *ED2 Recovery + Program* is a partnership between WCS and two health systems (Advocate Aurora and Ascension) under which WCS assigns peer specialists to hospital emergency rooms on a 24/7 basis to help address the needs of individuals who have overdosed (including from primary use of alcohol at Ascension). A primary goal is to connect such individuals with community-based care and treatment immediately upon discharge. Peer specialists also provide follow-up at least once per day for the first seven days after the participant’s discharge and at regular intervals thereafter. This new program is funded with grants from Wisconsin Voices for Recovery (a statewide recovery network supported by DHS) and, in the case of Ascension, by its foundation. WCS leaders say they would love to expand the program (134 persons were served in 2021) but they are limited by lack of funding.

The WCS leaders we interviewed cited a strong relationship with BHS, but like other interviewees they pointed to fragmentation among providers as a key “system” weakness (pointing out that all have their “separate lanes”). They cited Hub and Spoke as an effort to overcome that fragmentation by establishing a coordinated network of providers that consumers can easily navigate to serve their individual needs.

Summary of common themes voiced by BHS network providers

Overall, there were several important insights voiced by our multiple interviewees that we summarize below:

- **Increased residential treatment capacity and coordination.** Many of the interviewees pointed both to the need for more residential treatment beds in the community and for a better way to coordinate the use of those beds. BHS once served as the “gatekeeper” (or at least the keeper of the waitlist) but no longer plays that role given that many who seek such treatment do so directly with the service provider. One interviewee noted that this creates issues of fairness, as those seeking and receiving residential treatment might simply be most adept at navigating the system, and many such individuals use a substantial portion of available bed days because they cycle in and out of residential care.
- **More and varied forms of bridge and sober housing.** Virtually all interviewees also expressed the need for additional bridge housing to serve those who had been discharged from residential treatment and were in the early stages of recovery but needed stable, temporary housing (up to

¹¹ The federal Centers for Medicare & Medicaid Services specifies that health home providers “will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.” See this [link](#) for additional details.



90 days) in a sober environment to achieve success. This includes forms of such housing that would be available to families and in locations outside of the central city, where there is widespread access to substances. One interviewee noted that residential treatment providers “all compete for the same beds” as they look to discharge people from their care. Another noted that because residential treatment reimbursement from Medicaid is limited to 90 days, it is often necessary to release individuals before they are clinically ready and before they are effectively able to secure employment. Increasing the availability of sober housing and similar facilities to provide extra support to such individuals would help prevent relapse and ensure continued progression toward recovery.

- **Greater focus on alcohol.** Leaders from IMPACT were not the only interviewees who emphasized the need for greater focus on alcohol use disorders. One expressed a need for a greater array of services for those in the early stages of such disorders and noted that those whose only disorder is associated with alcohol are deemed a low priority and often must wait for services. Another noted that there is little, but much-needed, case management available for those whose sole disorder is related to alcohol.
- **“Bridge” to CCS.** Interviewees mostly expressed enthusiasm for the CCS program and said it would be beneficial to enroll more individuals with SUD into the program. However, a few noted that the several days or weeks typically required to enroll clients in the full array of CCS services creates both service-level and financial challenges. On the service side, one interviewee noted that some clients tend to “drop off” from receiving services while waiting, while others receive only minimal services and are prone to relapse. From a financial standpoint, providers may be required to pick up the costs for any services rendered between the time that the client is ready to be discharged and CCS enrollment kicks in, which can be a financial hardship for them.
- **Peer support is effective but peer specialists need to be supported.** Each of the organizations we interviewed cited the value of certified peer specialists. Having dealt with substance abuse themselves, peer specialists are in unique position to provide support. However, many of the organizations cited a shortage of such specialists, while interviewees from WCS – which performs a substantial amount of peer specialist training in the county and which employs 60-65 peer specialists – argued that the problem is not only the number of existing peer specialists, but

One Person’s Story

One of our interviewees was a peer specialist who cited her own story of recovery as an example of the need for more transitional, or “bridge” housing. She recounted how she had enrolled in at least a dozen treatment programs in attempts to end her heroin addiction and had experienced every level of care, “but nothing worked for me until I followed up my care with sober living.”

Most recently, she spent 30 days in a residential treatment program and then followed it up with nine months of sober living at 4th Dimension Recovery Center in Milwaukee. She summarizes her story this way:

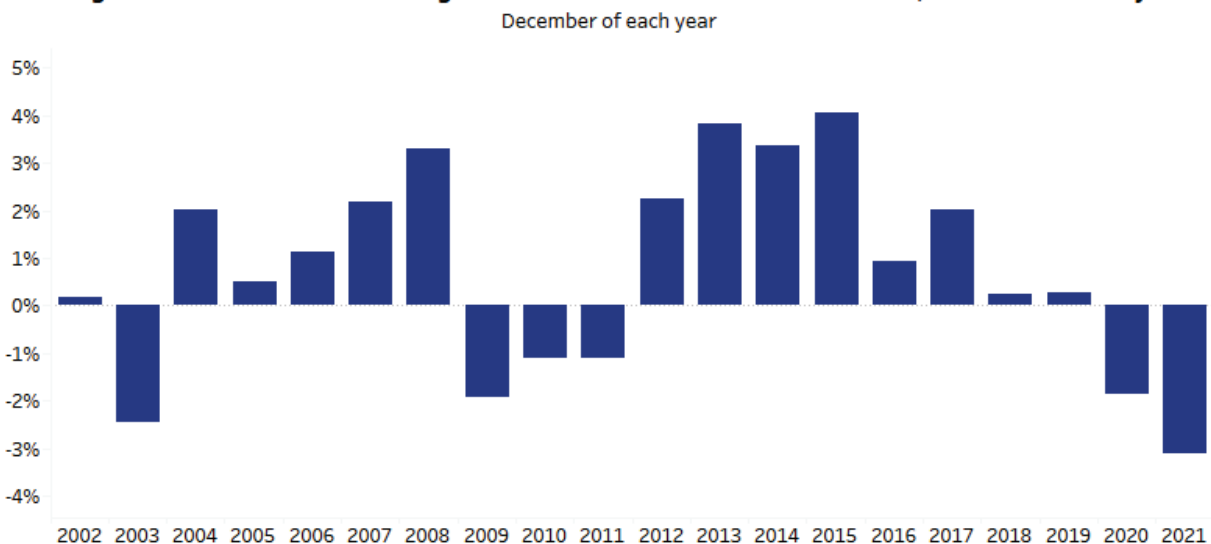
We must remember getting clean is just one part of the journey. This is a disease...and it takes years for our brain to recover and rewire. It took me living with other people on similar journeys. In my time at bridge housing, I was able to learn essential life skills that I never had attempted before. I was held accountable for my actions until I was able to learn how to hold myself accountable...I have been an addict for 15 years and it is just unrealistic to think I would be able to learn everything I need to stay sober in 90 days.



also the fact that pay is so low (typically \$16-\$17 per hour). Because of the low wages, the specialists often must work multiple jobs, which diminishes their availability or may cause them to leave the profession for higher wages. WCS leaders suggested that if BHS and Medicaid provide higher reimbursement for peer specialist services, then their current roster of specialists would be able to work additional hours and fill gaps in needed services (for example, additional peer specialist hours could allow WCS to have up to two specialists on call to serve Ascension and Advocate Aurora emergency departments at all times).

- Need for more staff and greater recognition by BHS of workforce challenges.** Almost all interviewees cited workforce challenges either within their own agencies or at other key players in the provider network as major obstacles to ensuring appropriate capacity within the “system.” A separate analysis by WPF shows the number of people employed in Milwaukee County in the “Health Care & Social Assistance” employment category decreased in 2021 by 3.1% (the largest percentage decrease in the past two decades, as shown in **Figure 14**) despite a likely increased demand for services. Some felt that investments in paid internships and stipends to encourage more individuals to enter SUD-related fields and stick with their education would be helpful. Others cited low pay for counselors and case managers and said BHS has failed to recognize the need to increase its fee-for-service payments to accommodate the efforts of employers to attract and retain workers in a high-inflation environment with an historically tight labor market.

Figure 14: Year-Over-Year Change in Healthcare & Social Assistance Jobs, Milwaukee County



- Need for greater service coordination in general.** A primary point of consensus among the interviewees was that there is little coordination between service providers in the BHS network and between them and private hospitals and health systems. One argued that such coordination was needed to ensure that there are overriding principles guiding how individuals with SUD are screened and referred, how services that are in great demand are prioritized, and where and under what programs those with different needs should be treated. Another suggested that more effort should be made to measure performance and outcomes and to direct public dollars to programs and services that can be shown to be most effective.



HOSPITAL-BASED SUD SERVICES

The list of SUD service providers in Milwaukee County extends to many providers – large and small – outside of the network that is linked in some fashion to BHS. The most prominent of those are local hospitals and health systems, which must maintain capacity to serve individuals who seek or are in need of immediate SUD treatment at their emergency departments. In addition, two of the three major health systems in the county provide an array of SUD treatment and recovery services, as does Rogers Behavioral Health, a major national provider of mental health and SUD services that has a robust presence in southeast Wisconsin.

In this section, we focus on major hospital and health system players and discuss their role in the SUD service “system” in Milwaukee County and how they interact with key players. Our primary data sources were interviews with leaders and SUD specialists from three health systems: Advocate Aurora, Ascension Wisconsin, and Rogers Behavioral Health, as well as reflections from BHS officials and BHS-funded providers.

Services provided

Each of the three systems we interviewed provides a range of SUD services:

- **Advocate Aurora**’s continuum includes traditional outpatient treatment provided at several affiliated clinics in the county (though mostly in Milwaukee); intensive outpatient services (IOP) – both in person at several locations and virtually; partial hospitalization¹² (mostly at its Aurora Psychiatric Hospital campus in Wauwatosa); residential treatment (30 beds) at its Wauwatosa campus; and detoxification services at its Wauwatosa campus and several hospital locations. Advocate Aurora interviewees also cited two special programs: Culver Alumni House, a group of eight peer-run apartments on the Wauwatosa campus that provide sober living arrangements for up to 15 individuals stepping down from residential care; and the Lighthouse facility on the Wauwatosa campus, which is a refurbished home once inhabited by the facility’s president that serves as a location for peer recovery support groups to conduct programming.
- **Ascension Wisconsin** offers MAT and assessment/referral services at its Ascension St. Francis and Ascension St. Joseph hospital locations in Milwaukee as well as inpatient addiction, detox, outpatient, and IOP services at various locations. Officials also cite a relatively new and growing Successful Opioid Addiction Recovery (SOAR) program, which was initiated at its Fox Valley locations and is now ramping up at the Ascension Columbia-St. Mary’s Milwaukee facility with the first four clients enrolled. The program is intended primarily for individuals who start in an IOP program and are in need of longer-term treatment for their opioid addiction. Ascension does not offer residential treatment services in Milwaukee County at this time.
- **Rogers Behavioral Health** similarly provides a full range of SUD services in Milwaukee County, including detoxification at its Brown Deer and West Allis locations, residential treatment services at West Allis (14 beds), and partial hospitalization and IOP at both locations. Rogers also provides a similar range of services at its facility in Oconomowoc and transitional housing at its Sheboygan campus – Milwaukee County residents sometimes are served at those sites. Rogers’

¹² Partial hospitalization, according to Medicare.Gov, “provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care.”



residential services – which it refers to as Mental Health Addiction and Recovery – include therapy services and medication evaluation at all levels of care, as well as MAT when it is clinically indicated. Certain services also are offered via telehealth. Finally, officials note they have the ability to transform inpatient mental health beds at their Milwaukee County facilities to detoxification beds (and vice versa) when community demand indicates the need to do so.

Clients and how they are referred

While each of the three private health systems seeks to meet the demand for SUD services from clients with private health insurance, each also serves clients who are insured through Medicaid or Medicare and the two general hospital-based systems emphasize that they do not turn away any patients in need of detoxification services who appear in their emergency rooms (Rogers also points out that its foundation can pay for services in emergency situations for individuals who lack health insurance coverage for its specific services, as does Ascension). Ascension officials estimate that about 75% of their SUD clients in Milwaukee County are covered by Medicaid, while Advocate Aurora places that estimate at 60%.

In terms of patient volumes, **Table 3** lays out the number of individuals served at Milwaukee County locations for each system in 2021 for the three primary SUD service categories they offer. Some individuals received more than one type of service so they would be counted in multiple columns.

Table 3: Individuals served by hospital-based systems for various SUD service categories, 2021

	Advocate Aurora	Ascension**	Rogers Behavioral Health
Detoxification*	507	224	1,713
Residential Treatment	279	NA	139
Day Treatment/IOP	859	653	936

* These are patients who accessed detox care at one of the health system’s inpatient behavioral health units in Milwaukee County (and in the case of Advocate Aurora, only on its Aurora Psychiatric Hospital campus in Wauwatosa). It does not include detoxification services provided on medical floors at Advocate Aurora general hospitals in Milwaukee County or at Ascension hospitals in Milwaukee County

** Ascension’s 2021 data covers its 2021 fiscal year, which extended from July 1, 2020 to June 30, 2021.

Referrals for SUD services at each of the three systems come from varied sources. Among the most prominent sources mentioned by each are walk-ins by clients themselves who have learned about the SUD services offered by the system; service navigators from Medicaid managed care organizations or commercial insurance companies; and other providers (including those in the BHS network) or health care professionals who recognize the need for an advanced level of SUD treatment that they cannot provide. The two general hospital-based systems also cite referrals from their emergency departments, and at least one also cited case managers from community-based organizations, the Milwaukee County justice system (including the county’s drug court), and other detoxification providers as sources of referrals.

Interaction with BHS and perceptions of service gaps

Each of the three hospital-based providers cited very little to no direct interaction with BHS and each opined that a change to that paradigm would be beneficial. One cited the lack of care coordination that occurs after patients are discharged and said it would be beneficial to work with BHS to ensure that such individuals are not simply given a phone number or two for outpatient or other service providers and instead ensure that real follow-up occurs. Another said it would be open to receiving



more referrals from BHS and its Access Point providers and to formally becoming part of the CARS-funded network. All three also indicated that they operate in silos and that a mechanism to bring all major SUD service providers in the county together on a regular basis would be helpful.

Other specific service gaps identified by the hospital-based providers include the following:

- **Detox** – one provider said its detoxification beds were “jammed,” while two cited a specific need for more capacity for those who do not reach the threshold for medically managed detox (typically for alcohol-related abuse) but still need some level of detoxification services. One BHS leader we interviewed suggested that it would be helpful for the hospital systems to expand their detoxification capacity to free up county dollars that are currently being spent for that purpose for other SUD priorities; all of the providers cited their own capacity challenges in response but one expressed openness to the concept if it could be coupled with county support for additional residential treatment beds.
- **Centralized database of community-based providers** – multiple interviewees expressed frustration with their inability to keep track of the various community-based providers of different SUD services and which ones may have capacity to serve their patients upon discharge. The notion of a county-developed and county-maintained centralized database to provide such information was conceptually supported by all interviewees, as well as a BHS role in organizing regular provider meetings. In a similar vein, one interviewee suggested that the county lead an effort to create a countywide advisory committee that would include the various public and private sector entities who are investing in opioid-related services and coordinate their investments in a strategic manner.
- **Sober housing/bridge programs** – multiple interviewees cited the challenges involved with finding housing for patients upon discharge and a specific need for forms of housing that would be available for those who still require medication (some sober housing facilities exclude such clients). Others cited a need for more “bridge” housing and services for those who have been discharged from inpatient/residential care but have not yet been able to access their next level of care, with one suggesting that a county-run program to provide medication to those who have been discharged pending their first appointment with an outpatient provider would be helpful. Unlike our interviewees from the BHS-funded network, the health system interviewees did not cite a significant capacity challenge for residential treatment beds, although one noted that its system provides a “mid- to high-end” residential service and a perceived need for more beds for those on Medicaid.
- **Workforce** – our interviewees were unanimous in expressing concern about workforce challenges, which were having a real impact on their capacity to treat SUD clients. However, most were skeptical about the role BHS could play in addressing such challenges.
- **Transportation** – one hospital-based provider cited substantial challenges faced by clients in securing reliable transportation to outpatient treatment providers. While DHS maintains a transportation program for Medicaid enrollees, this provider said the state system was unreliable and this could be an area where BHS and the county might contribute.



Views on prevention and education

There was consensus among interviewees that there is an immediate need for education-related activities surrounding fentanyl and the extent to which it is increasingly being laced into marijuana, cocaine, and other drugs. As one put it: “The prescription thing is what got us here but that’s not the big issue anymore for people getting addicted.” The hospital-based interviewees also shared the view of others we interviewed that education and prevention activities around alcohol should be stepped up given that it remains the leading source of substance abuse.

Summary

Leaders from the three major hospital-based systems that provide extensive SUD services in Milwaukee County described a comprehensive array of services that are not only serving private pay patients, but also large numbers of Medicaid recipients. Given BHS’ emphasis on serving low-income populations (while prioritizing those that lack any insurance), it would certainly appear that greater interaction between BHS and these providers would be warranted.

Moreover, we heard from the hospital-based systems – as we did from virtually all of our interviewees (including those from BHS) – that fragmentation among all providers in the county is a problem and that having a centralized means of identifying available capacity across the entire SUD service continuum would be helpful. Concerns voiced by the health system leaders about a lack of specialized housing and “bridge” services also were consistent with what we heard from others.



THE ROLE OF MUNICIPAL HEALTH DEPARTMENTS

Milwaukee County is unique among Wisconsin's 72 counties in that per state law, responsibility for the public health function is assigned to municipal governments instead of county government (which houses SUD services). There are 11 municipal public health departments in Milwaukee County (our February 2022 [report](#) provides details on their services and functioning).

There is considerable overlap between public health and SUD challenges, and the county's municipal health departments report growing levels of SUD-related activities in light of the opioid crisis and citizen input that SUD is a priority health concern. We conducted a group interview with five municipal public health officers or their designees and learned the following:

- Municipal health departments do not have much direct interaction with individuals who are seeking SUD services but they are active in prevention and education activities. While many once had some interaction with BHS with regard to those activities, their interaction today – with the exception of the Milwaukee Health Department (MHD) – is with Community Advocates, the largest BHS contractor for prevention and education.
- Suburban public health leaders felt that there generally is little effort made by BHS to work with them or initiate treatment and referral services in their communities. That contrasted with the views of MHD interviewees, who pointed to a close working relationship with BHS.
- The interviewees felt there are important efforts underway in the county to address prevention and education, but there is little alignment and coordination of those activities. They felt BHS might be the logical entity to promote such alignment, but expressed concern that a BHS-led effort would not pay sufficient attention to the suburbs.
- The interviewees felt ill-equipped to comment on where BHS might effectively invest additional resources because they did not have a clear understanding of the current service delivery system. That said, several cited the effectiveness of an overdose dashboard created by the county's Office of Emergency Management and one cited potential for BHS to serve as a collector and disseminator of SUD-related data to community-based agencies and local health departments.



PREVENTION AND EDUCATION SERVICES

Prevention represents the first line of defense against opioid addiction and is addressed at many levels of government. On the federal level, SAMSHA and the U.S. Department of Health and Human Services have developed prevention guidelines. The federal government also funds the Center for Substance Abuse Prevention in Rockville, Maryland and the Great Lakes Prevention Technology Transfer Center in Madison, Wisconsin, both aimed at prevention.

Prevention efforts involve both education and harm reduction. Education efforts typically consist of curricula and programming to raise public awareness and educate citizens about the dangers of substance use, while harm reduction efforts seek to reduce negative consequences associated with such use and often are viewed as a bridge between prevention and treatment services.

With regard to opioids, harm reduction efforts often include increasing the availability of Narcan (the brand name for Naloxone, a drug used in opioid overdose emergencies), as well as the distribution of fentanyl test strips. A broader view of prevention, which is identified in the State of Wisconsin Settlement Funds Proposal for the 2023 fiscal year, incorporates prevention efforts to address root causes of substance use in communities and includes increasing resilience, social connectedness, and equity as well as improving social determinants of health.

As mentioned previously, at least 20% of the SUD funding received by counties from the Substance Abuse Prevention and Treatment Block Grant (a federal funding source that the state distributes) must be directed at prevention. In addition, not only BHS, but also most municipal public health departments in Milwaukee County engage in prevention and education activities.

In January 2022, the Wisconsin DHS conducted listening sessions to determine how best to allocate the opioid settlement dollars that will be received by the state. Prevention was an area that received considerable feedback, including specific recommendations that the state “provide evidence-based education, especially in K-12 schools, as well as in communities” and that it “consider including the voices of those with lived experience to reduce stigma in communities.”

The importance of prevention efforts was emphasized by each of the SUD providers we interviewed (both those supported by BHS and private health systems). Yet, despite the range of SUD-related activities conducted by most of these organizations, all focus primarily on treatment and their prevention efforts were aimed primarily at harm reduction efforts related to Narcan and fentanyl test strips. We did not observe an ability on the part of these providers to develop and implement substantial evidence-based prevention and education activities into their programs. It appears, therefore, that complimentary prevention and education programs are needed and warranted.

Milwaukee County CARS has made efforts in this direction. CARS currently has a full-time Prevention Manager and also allocates grant money to community organizations to conduct prevention activities. BHS also recently added a second employee to its prevention staff. One of our interviewees suggested, however, that BHS should invest more in education and prevention activities in its Wraparound program for youth.

Among the prevention efforts initiated by CARS is the promotion of evidence-based and evidence-informed strategies and materials that it makes available to a network of organizations county-wide. The CARS Prevention Manager identified four primary areas where BHS’ efforts are directed:



- Training
- Facilitating/Implementing
- Funding
- Convening

CARS' materials focus on areas such as education, information dissemination, development of alternatives for activities without drugs, problem identification and referral for individuals exposed to multiple risk factors for substance abuse, community-based networking activities and technical assistance, and the creation of strategies to impact legislation and policies. CARS also connects organizations to prevention funding, coordinates their efforts, gathers and analyzes data, and trains prevention providers. It also participates in harm reduction efforts in the community, such as the distribution of medication deactivation bags for the safe disposal of unused medications, lock boxes for medications with addictive components that are used in private residences, and test strips that can detect the presence of fentanyl in other drugs prior to ingestion.

CARS recently implemented a new “Better Ways to Cope” initiative that has awarded grants ranging from \$60,000 to \$100,000 in the following areas:

- Education
- Information Dissemination
- Alternative Activity
- Problem Identification and Referral
- Community-Based Process
- Environmental Strategy

Also, outside of that program, BHS awarded more than \$1.3 million in prevention grants to four community-based organizations in 2021 (as mentioned in an earlier section): Community Advocates, House of Kings and Priests, Safe & Sound, and the Social Development Commission.

Community Advocates prevention program

Community Advocates, a Milwaukee-based nonprofit, is the largest recipient of CARS prevention dollars, receiving \$760,000 in 2021. The Community Advocates contract is broken into two parts. A \$316,600 portion comes from the Division of Milwaukee Child Protective Services (DMCPS) and focuses on prevention interventions for youth and families. The remainder (\$443,400), and all other prevention contract funding, comes from block grant dollars and tax levy. Those funds support evidence-based prevention strategies, with a focus on primary prevention, use of evidence-based curriculum, and public health strategies such as coalition building.

Community Advocates works on prevention activities throughout Milwaukee County, often involving municipal public health department leaders and staff. Community Advocates also provides sub-grants to other community-based agencies to support activities like placing evidence-based curriculum into classrooms and developing resilience skills. In addition to these efforts, Community Advocates uses additional funding from the Wisconsin Department of Health Services to provide technical training in SUD prevention. **Table 4** on the following page summarizes the agency's primary prevention activities and outcomes per information we received directly from Community Advocates.



Table 4: Community Advocates prevention activities and outcomes

ACTIVITIES	OUTCOME MEASURE
CA administers the Milwaukee County Substance Abuse Coalition (MCSAP) and work groups which meet bi-monthly as the forum for prevention and activity implementation in the following areas: <ul style="list-style-type: none"> • Executive • Multi-Drug Prevention • Prescription Drug/Opioid Prevention • Data and Evaluation • Mental Health Wellness 	33,960 individuals online and in person reached by prevention activities. In addition, 29 million impressions were generated thanks to prevention-focused mass media 15,425 copies of prevention materials were distributed
MCSAP Wellness Work group designed a work plan for mental health wellness activities to be implemented utilizing the Strategic Prevention Framework	
CA staff and MCSAP partners implement planned block grant primary prevention activities per work plan	26 prevention activities were conducted by CA PPI staff and MCSAP partners 2,569 residents attended outreach events and community presentations
MCSAP Data & Evaluation Committee Tracks materials distributed and activities implemented to support increased exposure to prevention activities in the county	
MCSAP Executive Committee releases mini grants for administration of selected evidence -based curricula (Botvin LifeSkills Training Middle and High School Programs)	Botvin LifeSkills reached 1395 students 599 youth enrolled in LifeSkills completed the programming
Selected partner grantees confirm sites for LifeSkills implementation	90% of youth who completed survey (441) said they increased their knowledge, attitudes, and skills needed to make good choices or prevent harmful behavior
Selected partner grantees facilitate curriculum CA staff implements 5 training courses annually at PPI Training Center or community locations	83 prevention professionals are reached with evidence-based training
	68 (90%) of prevention professionals who complete each training indicate positive outcomes achieved

Community Advocates sees a need for additional funding for harm reduction activities and would also like to offer incentives for program attendance (e.g. providing food at prevention events). Their funding sources currently restrict expenditures in these areas.

In the area of harm reduction, agency officials say the community could benefit from additional needle exchange programs, better community understanding to reduce stigma associated with treatment, more medication-assisted treatment (MAT)¹³ facilities, and alternative ways to access Narcan that do not require access to a computer.¹⁴ Unfortunately, financial support for these programs would require different forms of funding in light of the federal block grant restrictions.

Overall, our discussions with Community Advocates leaders about service gaps mirrored input we received from other local service providers, including a lack of treatment capacity; the need for

¹³ Medication-assisted treatment (MAT) is [defined by SAMHSA](#) as the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

¹⁴ BHS officials say they are actively working on this strategy, with plans to strategically place “Nalox Boxes” throughout the community.



better coordination of provider efforts; and the importance of addressing alcohol as a gateway drug. They also cited an opportunity for BHS to serve in a more pronounced coordination capacity – both for treatment and prevention activities.

Model programs

We also conducted desk research to identify model prevention programs that possibly could be considered for replication in Milwaukee County with opioid settlement dollars. Per the recommendation of staff from the Great Lakes Prevention Technology Transfer Center in Madison, we reviewed a program called Blueprints for Healthy Youth Development at the University of Colorado-Boulder Institute of Behavioral Science. The program’s mission is to provide a comprehensive registry of scientifically-proven and scalable interventions that prevent or reduce the likelihood of antisocial behavior and promote a healthy course of youth development and adult maturity.

The program’s [website](#) discusses three model programs linked to prevention:

- *LifeSkills Training*: A classroom-based substance abuse prevention program designed to prevent teenage drug and alcohol abuse, tobacco use, violence and other risk behaviors by teaching student self-management skills, social skills, and drug awareness and resistance skills. (This is the program used by Community Advocates.)
- *Positive Action*: A school-based social emotional learning program for students in elementary and middle schools to increase positive behavior, reduce negative behavior, and improve social and emotional learning and school climate.
- *Project Towards No Drug Abuse*: A classroom-based drug prevention program designed for at-risk youth that aims to prevent teen drinking, smoking, marijuana, and other hard drug use.

Contact information and access to program materials are provided on the Blueprints website.

Summary

The need for effective, evidence-based prevention programs has been identified and is supported nationally, by the State of Wisconsin, and by BHS and local SUD prevention providers. Provider organizations in the CARS SUD network also see prevention as essential and they support the development and coordination of prevention efforts in the county.

Meanwhile, the CARS prevention staff is well-situated and is already acting in many respects as a convener and coordinator of prevention efforts. This effort is needed and it appears that it would be worth considering an expansion of this role with a portion of the county’s opioid settlement dollars.



SEVERAL AGENCIES AND PARTNERS FOCUS ON SUD PREVENTION AND HARM REDUCTION

Outside of the prevention and harm reduction programs funded by Milwaukee County are dozens of statewide and local efforts. While too numerous to describe in detail, we highlight some of those here.

The Wisconsin Department of Health Services (DHS) website features a page on [Prevention and Healthy Living](#) with resources related to a wide range of topics including alcohol, opioids, tobacco, and other health issues such as chronic illnesses, nutrition, and exercise. The [Small Talks](#) campaign aimed at preventing underage drinking provides parents and caregivers with resources for having age-appropriate conversations about alcohol with kids as young as five years old, and also features a library of [partner resources](#). The DHS website also has a section devoted to [opioids](#) with facts, data, and information on safer use, overdoses, safe disposal, and treatment and recovery.

With regard to harm reduction, DHS participates in the [Narcan Direct program](#), which provides Narcan free of charge to organizations to distribute alongside trainings on identifying opioid overdoses and using Narcan to prevent overdose deaths. Per the [DHS website](#), agencies that may apply to participate in the program include county or municipal public health departments, tribal health clinics, syringe access programs, and community organizations that employ recovery coaches and certified peer specialists.

DHS also organizes twice yearly [Drug Take Back Days](#), often in collaboration with local organizations, which help to keep unused or expired medications from misuse; and maintains permanent [drug drop boxes](#) and a library of [partner resources](#), including articles, flyers, posters, and videos. An additional statewide resource, Wisconsin 211, maintains a searchable [map](#) of where to find Narcan/Naloxone.

Locally, there are also substantial resources available. Most are focused on opioid prevention or harm reduction, with Naloxone trainings and distribution among the most commonly offered.

For example, the Milwaukee Fire Department distributes [HOPE kits](#) (with financial support from BHS), which include two doses of Narcan with an instruction card reminding users how to administer it, a CPR face shield, two fentanyl test strips, and information cards detailing community resources. These can be [requested for free](#) from any firefighter/paramedic or fire station, no questions asked.

[Milwaukee County Substance Abuse Prevention](#) is a coalition of community partners (including BHS and local health departments) that works to prevent and reduce substance abuse, including problematic drinking, prescription drug abuse, and youth marijuana use. The coalition also partners with Community Advocates, Hayat Pharmacy, and Uptown Pharmacy and Wellness to [provide medication lock boxes and safe disposal pouches](#) and drug takeback days.



SEVERAL AGENCIES AND PARTNERS FOCUS ON SUD PREVENTION AND HARM REDUCTION

Other local community-based organizations offering SUD prevention and harm reduction programming include Vivent Health, which has a [Lifepoint](#) program that offers needle exchange, clean supplies, fentanyl test strips, and Narcan free of charge along with confidential counseling and testing; UMOS, which offers needle exchange, access to drug treatment, and naloxone training and distribution; Sixteenth Street Community Health Centers, which provides syringe exchange and Narcan at their [Community Prevention Center](#); and Safe & Sound, which formed a [27th Street West Drug Free Coalition](#) in the 53208 ZIP code to prevent youth alcohol and marijuana use.

Other organizations have a more personal connection to addiction and overdose. [MKE Overdose Prevention](#), which organizes community trainings and distributes Narcan, was started by a woman who is in recovery from opioid addiction. The group has held community [trainings](#) at Company Brewing, The Daily Bird, and Riverwest Coop as well as with the group Femmes With Bikes. The Daily Bird, a coffee shop, also keeps [Narcan behind the register](#).

The [Milwaukee Heroin Diaries](#) is a collaboration between individuals, churches, non-profits, and other groups that shares information on how to access naloxone trainings as well as Narcan and test strips. They also connect people with treatment options and provide education and support for families and others affected by addiction.

In addition to these ongoing efforts by local organizations, other entities have hosted numerous stand-alone events. For example, Clean Slate Milwaukee, the Milwaukee Office of African American Affairs, and Vital Strategies hosted a [collaboration](#) at Milwaukee's Juneteenth Celebration to share information on opioids and promote an upcoming Narcan training and distribution event. Also a recent drug take-back [event](#) with Narcan training and free Narcan was held by Near West Side Partners, the Milwaukee Fire Department, and Safe & Sound.



INSIGHTS AND CONCLUSION

The National Institute on Drug Abuse estimates that the use and misuse of alcohol, nicotine, and illicit drugs, combined with the misuse of prescription drugs, costs Americans more than \$700 billion each year in increased health care costs, crime, and lost productivity.¹⁵ Appropriate treatment and recovery efforts are essential, therefore, both from the standpoint of the health and welfare of those suffering from addiction as well as the economic well-being of the community.

Milwaukee County residents are fortunate to have a full continuum of SUD services and a broad array of service providers. BHS now has its best opportunity in decades, however, to enhance the coordination and expansion of those services. The availability of outside funding for the development of new and enhanced programs is rare in government settings. The opioid settlement funding gives BHS such an opportunity, either through direct investment of its allotment, or via indirect investment made possible by the ability to free up other resources from the use of settlement dollars.

In our data gathering, interviews, and analysis of the SUD landscape in Milwaukee County, we uncovered several important specific programming and funding needs. Yet, in addition, we heard from almost all of our key informants that there are larger, structural problems that must be addressed. Indeed, a common sentiment voiced by our interviewees is that current SUD services are delivered not as part of a coordinated system of care, but as a fragmented and incomplete array of services by dozens of providers who operate largely in their own respective service lanes.

We heard from several providers, for example, that clients sometimes are not appropriately enrolled in programs because information is lacking on who is offering what services and which programs have treatment capacity. We also heard that while clients are able to access detoxification treatment without much difficulty, they are often discharged without a follow-up treatment plan at the time when their need for further assistance is critical. Finally, we heard that many clients' need for recovery in safe environments cannot be fulfilled because the correct form of transitional housing is not available, and that the services they are receiving even before the need for transitional housing materializes often must end prematurely because of funding restrictions.

BHS' current opportunity could allow it to focus even more on the holistic needs of individuals who are seeking treatment for their addiction and to play the lead role in building a coordinated and comprehensive treatment and recovery system. This role could include:

- Organizing a **coordinated and comprehensive network of providers across Milwaukee County** (including both health systems and community-based providers) that BHS would support by collecting and analyzing data; spearheading the development of a common information technology platform; facilitating regular provider meetings at which knowledge would be shared and service gaps identified and addressed; and coordinating treatment options to ensure an adequate continuum of services while preventing unnecessary duplication.
- Establishing **non-duplicative and synchronized countywide prevention and education programs** that might expand the existing role of Community Advocates with additional investment and inclusion of other entities working in this area that are not part of the

¹⁵ <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/introduction>



Milwaukee County Substance Abuse Prevention coalition. This effort also could entail a greater emphasis on harm reduction and would logically involve an enhanced role by BHS in coordinating the efforts of municipal public health departments and ensuring appropriate prevention, education, and harm reduction activities in both Milwaukee and its suburbs.

- Coordinating and **investing in system-wide workforce development efforts** to help address workforce shortages that we observed across all SUD service providers. On a narrow scale, investments could include funding for paid internship programs that would encourage students to pursue careers in the field, as well as financial support for training and increased compensation for peer support specialists. Overall, BHS could be charged with analyzing workforce challenges on a systemic basis and working with all SUD providers to identify and develop strategies to address the most acute workforce gaps.
- **Investing in areas where current treatment gaps are most glaring and in services that recognize the long-term nature of addiction** and the myriad challenges that arise on the road to recovery. These enhanced investments logically would include Increased residential treatment and bridge housing beds, creation of additional safe recovery environments, and support for services that address the full range of social determinants of health, including transportation and employment. Also, such efforts should focus not only on increasing numbers of available beds, but also on providing financial support where appropriate to increase allowable lengths of stay. Expanding existing successful models in Milwaukee County to fill treatment and recovery gaps – like the Oxford House, Meta House’s bridge housing for families and pregnant and post-partum women, and WCS’ Outpatient Plus and ED2 Recovery + programs – might turn out to be a better use of resources in this regard than investing in new program creation.

Working toward these broad goals would be a long-term endeavor. It also should be recognized that the funding currently available through the opioid settlement – while substantial – may arrive over a period of years and may not be sufficient, in and of itself, to make such major changes. In addition, it is not clear whether these resources must be directed exclusively to programs that specifically are designed to serve those whose primary substance of abuse is an opioid, or whether there is leeway to invest in programs and services that are relevant to all forms of SUD, including opioids.

Regardless, this new funding may find its greatest use, initially, as start-up funding for new or enhanced services or for one-time uses like program development; enhanced information technology to promote a more systemic approach to treatment and follow-up; or brick-and-mortar investments in new housing or treatment facilities. In the short term, BHS and its stakeholders might therefore frame their deliberations by considering the following categories for investment of settlement monies and other resources freed up by those monies, as well as dollars that may now be available because of recent changes in Medicaid reimbursement:

1. Invest in Residential Treatment and Housing

- Use settlement monies for bricks and mortar investments in residential, bridge housing, “damp” housing (i.e. housing where some limits on substance use are imposed), and other housing needs.
- Use underspent TANF funds to help reimburse for family-centered treatment services in residential settings.



- Enhance the number of residential treatment slots and increase room and board reimbursement rates.

2. *Address Funding Flaws*

- Use settlement or freed up resources to address the lack of available reimbursement for services for individuals not eligible for TANF or those whose primary substance of use is alcohol, cocaine, or other non-opioid substances.
- Use these monies to extend residential treatment reimbursement beyond 90 days when needed.
- Use these monies to allow or expand reimbursement for CCS providers to serve clients before they are fully enrolled.

3. *Invest in BHS' Role as Coordinator and Gatekeeper*

- Invest in staff and technology to allow BHS to serve as the gatekeeper for those seeking or needing residential treatment services; in this role, BHS would seek to ensure equal access to all and prioritization of those most in need of residential services.
- Invest in staff and technology to allow BHS to serve as data collector from all major service providers and disseminator of information on where there is available capacity and which services are producing desirable outcomes; as part of this role, BHS also could serve as the overall “system” coordinator or perhaps invest more to allow for the expansion of WCS’ Hub and Spoke program to play that role.
- Coordinate communications, policies, and procedures between county-funded Access Points and local hospitals to ensure proper care coordination and follow-up after hospital discharges.
- Provide necessary resources to allow BHS access clinics at federally-qualified health centers to become true Access Points for SUD services.

4. *Address Other Pressing Service Gaps*

- Increase various fee-for-service rates to help community-based providers recruit and retain needed staff.
- Create stipends for interns working at nonprofit providers.
- Steer settlement and other freed up resources toward social determinants like transportation, employment, and social and peer support.
- Recognizing that alcohol use disorder is a potential gateway to opioid usage and continues to be a major public health concern in Milwaukee County in its own right, expand available services for those whose primary substance of abuse is alcohol, including a possible expansion of the AODA TCM program.
- Invest more in peer specialist pay and training.
- Urge and perhaps incentivize health systems to increase their hospital-based detox capacity (perhaps in return for having the county fund more residential treatment services).



5. *Bolster Prevention and Harm Reduction*

- Step up public education about the dangers of marijuana and cocaine laced with fentanyl.
- Do more prevention and harm reduction work with suburban communities.
- If politically feasible, consider investing in safe injection sites.

Finally, as BHS works to strengthen its role within the SUD landscape in Milwaukee County, it is incumbent upon the agency to be flexible and watchful of other efforts happening across the country and in other governments across Wisconsin. The opioid settlement dollars are triggering impressive new initiatives and much can be learned in terms of best practice models by paying careful attention to those efforts.

Overall, we hope our analysis will provide BHS, the Milwaukee County Mental Health Board, county policymakers, and other SUD providers and stakeholders with useful information that will assist them in making the most of their unique opportunity to address a critical public health need. While this report provides only a high-level starting point in that discussion, we are hopeful that it will steer the conversation in a thoughtful and informed direction.

